DOCUMENT RESUME

ED 320 272 EA 021 933

TITLE Reducing the Risk: A School Leader's Guide to AIDS Education, Volume 2. Leadership Reports.
INSTITUTION National School Boards Association, Alexandria, VA.
SPONS AGENCY Center for Chronic Disease Prevention and Health Promotion (DHHS/CDC), Atlanta, GA. Adolescent and School Health Div.
PUB DATE 89
CONTRACT U62-CCU302799-01
NOTE 49p.
AVAILABLE FROM Publication Sales, National School Boards Association, 1680 Duke Street, Alexandria, VA 22314 ($5.00 prepaid plus $1.25 postage and handling).
PUB TYPE Guides - Non-Classroom Use (055) -- Reports - Descriptive (141)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS *Acquired Immune Deficiency Syndrome; At Risk Persons; Behavior Change; *Behavior Modification; *Board of Education Role; Communicable Diseases; Community Attitudes; Disease Control; Elementary Secondary Education; *Health Education; Health Promotion; Moral Values; Physical Health; *Prevention; Venereal Diseases

ABSTRACT

Human Immunodeficiency Virus (HIV) infection first and foremost is a medical problem, but it entails a host of other problems--social, moral, ethical, legal, and fiscal--with numerous and complex implications for the entire community, including schools. Public health officials stress that the combined efforts of federal and state governments, schools, local agencies, and national and local organizations are needed to combat the spread of this deadly virus. Because education is the most effective means for controlling the epidemic, education to prevent HIV infection should focus on those people who practice risky behaviors, including school-age youth. The results of a 1987 study of sexually active teenagers, however, show that knowledge alone will not have the desired effects on adolescents; HIV education must focus on behaviors. While the best way to approach HIV education is to educate the entire school staff--with special emphasis on inservice sessions for teachers--before students receive classroom instruction, ultimately HIV education responsibility belongs to local school boards. As the appointed officials of their local schools, board members are in the best position to ensure that an HIV education program reflects community needs and values and is designed and implemented appropriately and effectively. (59 references) (KM)

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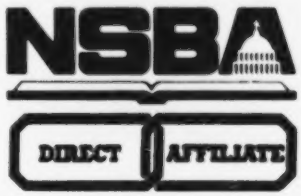

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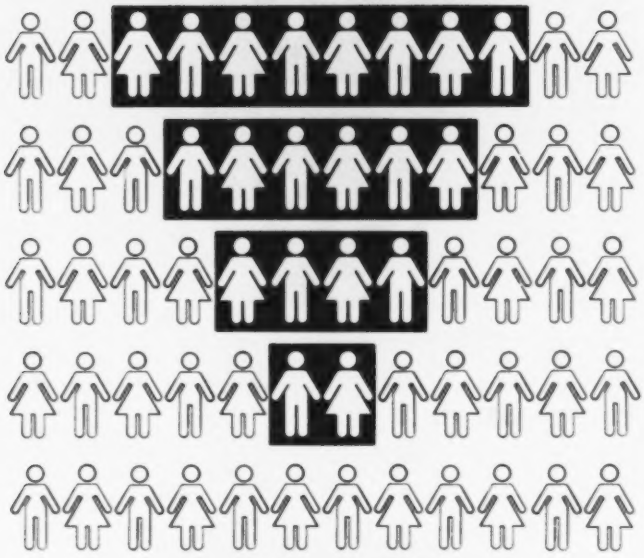
REDUCING THE RISK



A School Leader's Guide to AIDS Education

LEADERSHIP REPORTS

A publication for NSBA Direct Affiliates

Volume 2

NSBA

REDUCING THE RISK

A School Leader's Guide to AIDS Education

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This publication was completed with support provided by a cooperative agreement (Number U62/CCU302799-01) with the Division of Adolescent and School Health, Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control, Atlanta, GA 30333.

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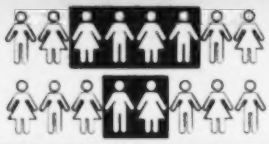


FOREWORD

Each day it becomes more critical that effective educational strategies be implemented to help people protect themselves from infection with the human immunodeficiency virus (HIV) — the AIDS virus — and behave responsibly in the face of the serious threat to health posed by this infection. Each day it becomes more critical that our youth know how to reduce their risk of infection with HIV so they can grow up to be healthy and productive citizens in a caring society.

The National School Boards Association is committed to empowering local school leaders to make a difference in the battle against HIV infection. We recognize that an important way to stop the further spread of HIV infection is through effective education. We believe that local school boards are the logical and compelling public education forum for any serious effort that addresses the critical need for a program of HIV education and prevention in the school community. This report provides school leaders with information to assist in making appropriate decisions and providing leadership that will result in effective HIV education in the nation's schools.

NSBA is privileged to be among the first 15 national organizations funded by the federal Centers for Disease Control (CDC) to promote increased and effective HIV education for school-age youth. The CDC cooperative agreement, which was awarded in September 1987, has enabled NSBA to continue providing national leadership in addressing the educational, legal, and policy issues surrounding HIV infection and AIDS and to emphasize that the further spread of the epidemic can be prevented through effective education. This report is one of the products supported by the agreement with the CDC.

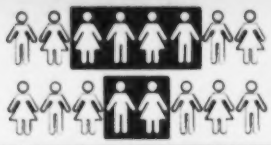
We urge you, local school leaders, to read this report and use it to guide and assist your HIV education efforts. It provides sound information not only on reducing the risk of HIV infection through education, but also on reducing the risk of controversy surrounding HIV education in your community and the risk of providing education that may be inadequate to the crisis we all face.

School leaders, particularly school board members, typically wear several hats as community leaders. The knowledge and skills you acquire regarding AIDS and HIV education will empower you to provide effective leadership, not only in your role as a school leader, but where you work, pray, and through your other civic and recreational activities. Thus, you and your colleagues can make a significant contribution to preventing the spread of HIV and to fostering rational and responsible attitudes toward those already infected.

Very truly yours,

Leonard Rovins
President

Thomas A. Shannon
Executive Director



PREFACE

In its June 1988 report, the Presidential Commission on the Human Immunodeficiency Virus reflected a growing consensus by stating:

> *The term "AIDS" is obsolete. "HIV infection" more correctly defines the problem. The medical, public health, political, and community leadership must focus on the full course of HIV infection rather than concentrating on later stages of the disease (ARC and AIDS). Continual focus on AIDS rather than the entire spectrum of HIV disease has left our nation unable to deal adequately with the epidemic.*

In spite of the Commission statement, a conscious decision was made to retain the term "AIDS" in the title of this report. In just a few short years, "AIDS," which stands for acquired immunodeficiency syndrome, has become part of our everyday vocabulary. It is the term used by the mass media, and continues to be used in public education campaigns such as the U.S. Department of Health and Human Services campaign, *America Responds to AIDS.*

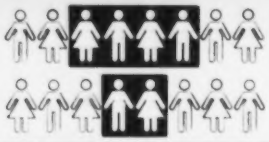
Nevertheless, it is not too soon to begin educating students and the public about the difference between HIV, HIV infection, and AIDS. These are three key terms that should not be used synonymously or interchangeably. They are defined as follows:

HIV: The name of the organism (germ) — human immunodeficiency virus.

HIV infection: The state of being infected with HIV. Development of antibody to HIV is clear-cut evidence of infection with the virus.

AIDS: The clinical term for the severe condition that frequently results from years of HIV infection and often is life-threatening.

The content of this report attempts to reflect these definitions. For example, AIDS education is referred to as HIV education; the AIDS virus is referred to as HIV. In discussions about state mandates, which frequently use the term "AIDS" in official documents, or in discussions of existing school district programs, which most often refer to "AIDS" education, the terminology has been changed to HIV unless the actual title of a program includes the term "AIDS" and is referred to. Exceptions to this guideline also are made in quoted materials.



CONTENTS

Introduction 1
- The Current Toll and Projections
- Implications for Schools
- Federal Actions on HIV Education
- Education Initiatives by States
- Efforts of National Groups
- Action by the Private Sector
- Cooperation and Collaboration Are Needed

Chapter I: The Imperative for HIV Education 7
- The Threat to Young People
- High Risk Factors for Adolescents
- Reaching Those Most at Risk
- Misconceptions Exist Among Adolescents
- The Role of Schools

Chapter II: The Promise of HIV Education 13
- HIV Education Must Focus on Behaviors
- HIV Education Can Be Effective
- Comprehensive Health Education

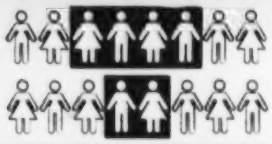
Chapter III: Overcoming Barriers to HIV Education 15
- Apathy Toward HIV Education
- Misinformation and Media Hype
- New Information
- Moral and Religious Concerns
- Concerns About Homosexuality
- Attitudes About Sexuality
- Uncertainty About Appropriate Instruction
- Concern About Degrees of Specificity
- Unprepared or Unwilling Teachers
- Parental Objections
- Legal Challenges

Chapter IV: A Policy Framework for HIV Education 19
- Policies Establish Goals and Guide Process
- Assuring Program Acceptance
- Value of a Policy on HIV Education
- Assuring Program Effectiveness
- Staff Training
- Educating the Public
- School-Community Advisory Committees
- Collaboration with Health Authorities and Others
- Ensuring Consistency

Chapter V: Curriculum and Instruction 27
- Goals of HIV Education
- Practical Program Considerations
- Course Content
- Selecting and Evaluating Curriculum
- Selecting and Training Teachers
- Keeping the Curriculum Up-to-Date
- Evaluating the Program

Epilogue: The Challenge for School Leaders 35

Resources 37



INTRODUCTION

The face of AIDS is the face of our young people. One out of every five cases of AIDS has occurred among persons 20 to 29 years of age or younger. Behind all the statistics and ghastly projections, AIDS increasingly is assuming the familiar face of a neighbor, coworker or a family member.

Public health officials are convinced that the reported cases of AIDS — more than 80,000 as of January 1989, represent only the tip of the iceberg. More frightening to contemplate is the number of people currently infected with the human immunodeficiency virus (HIV) who are not yet showing symptoms.

Adolescents are among those now infected and among those at high risk of becoming infected. The long incubation period between infection with HIV and symptoms of AIDS may give teens a false sense of invulnerability because none of their peers are known to have AIDS, though some of them may be infected. By 1991, officials say, AIDS may be a leading killer of young adults in the United States.

This report is about HIV infection and what schools can do to help young people protect themselves and stop the spread of HIV infection. The following pages contain information about the epidemiology of AIDS and HIV infection, the threat of HIV infection to young people, the need for HIV education and policy, considerations for making curriculum and instruction decisions, and resources for school officials to use in the fight against the HIV epidemic.

What Is AIDS? What Is HIV?

Acquired immunodeficiency syndrome (AIDS) is a medical term for a variety of severe conditions related to the breakdown of the body's immune system as a result of infection with the human immunodeficiency virus (HIV), often referred to as the AIDS virus. A damaged immune system leaves a person vulnerable to a wide range of opportunistic cancers and infections — illnesses that a healthy immune system fights off easily. AIDS is the final stage in a continuum of conditions resulting from infection with HIV. This continuum ranges from asymptomatic HIV infection (evidenced by development of HIV antibodies), to HIV infection with symptoms, and ultimately to AIDS.

An expanding body of research confirms that the virus is transmitted in three ways:

- Through vaginal, anal, and possibly oral intercourse with a person infected with HIV.
- Through direct entry of infected blood or blood components into the bloodstream, particularly by sharing needles and syringes with an infected person during intravenous (IV) drug abuse. In 1985, all blood banks began testing donated blood for HIV antibodies. Before 1985, the treatment of hemophilia with blood clotting factor concentrate carried high risk for HIV infection. Now, with screening and heat treatment, this product is much safer with regard to transmission of HIV.
- From mother to child in utero, during childbirth, or through breast-feeding.

No vaccine exists to provide immunity to HIV, nor is there a cure for AIDS or HIV infection. Recent tests with drugs such as zidovudine (previously referred to as azidothymidine, or AZT) have suggested that the course of the disease can be slowed, and clinical trials are underway to try to prevent or delay the onset of AIDS in HIV-infected persons.

Asymptomatic persons with HIV infection who look and feel healthy may infect other persons without realizing it. Several years may pass before an infected person shows clinical symptoms of HIV infection or AIDS. As few as a couple of months or as many as 10 or more years may pass from the time of HIV infection until the onset of symptoms. Although many deaths occur within two years of the disease's appearance, some patients have survived for five years and longer and new treatments are becoming available that seem effective in prolonging patient survival.

It is possible to become infected as a result of one exposure to infected blood, semen, or vaginal fluid; the risk seems to increase with repeated exposure through sexual intercourse or through sharing IV needles with HIV-infected persons. Also, research

(continued on page 2)

presented at the Fourth International Conference on AIDS in June 1988 supports the theory that certain cofactors, particularly genital sores associated with syphilis or herpes, increase a person's susceptibility to infection with HIV through sexual intercourse.

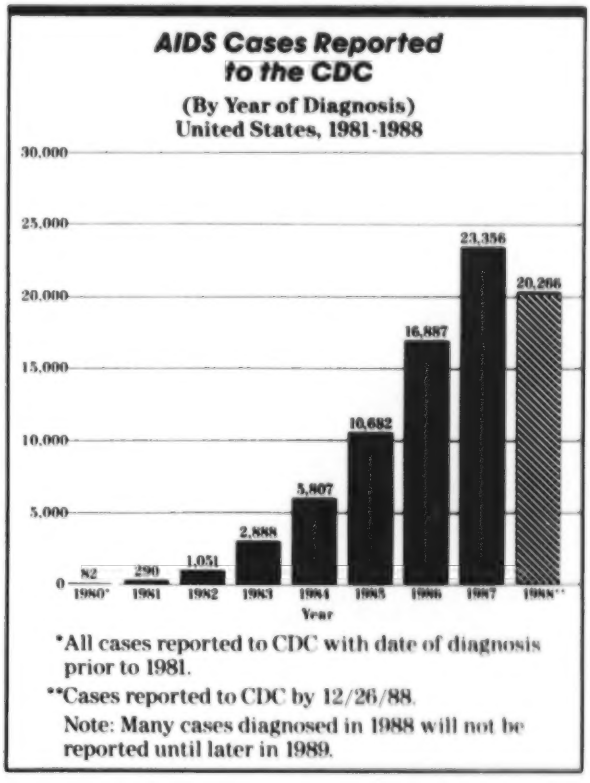
Numerous scientific studies have shown that the AIDS virus, HIV, is not spread by indirect or casual (nonintimate) contact — for example, sneezing, shaking hands, hugging, perfunctory kissing, or being in the same classroom with someone who is infected. Dozens of these studies were cited in a *Journal of the American Medical Association* article (Vol. 259, No. 9, March 4, 1988), "Do Alternate Modes for Transmission of Human Immunodeficiency Virus Exist?" Author Alan R. Lifson, M.D., M.P.H., concluded, "It is necessary for all individuals to be aware of how HIV is transmitted to reduce high-risk behaviors. It is equally important for the public to be aware of how HIV is not transmitted to avoid unnecessary fears and actions."

Although the virus has been found in the tears, urine, and saliva of some infected persons, there are no documented cases of transmission through these mediums. A small number of health care workers have become infected through direct contact with HIV-infected blood. Among all AIDS cases reported in the United States, the cause of HIV transmission is undetermined in only three percent. These cases include patients for whom information is incomplete (due to death, refusal to be interviewed, or loss to follow-up), patients still under investigation, and interviewed patients for whom no specific risk was identified through interview.

Latex condoms, when properly used, have been shown to be effective as a barrier to HIV. But they are not foolproof. When used with contraceptive jelly, cream, or foam containing nonoxynol-9 or other spermicides which have been shown to kill HIV in laboratory studies, condoms are believed to be the most effective means of preventing HIV spread among persons who engage in sexual intercourse and who are not maintaining a mutually monogamous relationship. Condoms also are useful for those monogamous couples where one partner is infected.

The Current Toll and Projections

By January 1989, more than 80,000 cases of AIDS had been reported to the federal Centers for Disease Control (CDC) in Atlanta. Of the people diagnosed with AIDS, 56 percent, or more than 46,000 people, had died. Sixty-two percent of the reported cases were among homosexual or bisexual men; 19 percent were among IV drug abusers; eight percent were both homosexual males and IV drug abusers; four percent were designated as resulting from heterosexual transmission; three percent were due to transfusions of blood or blood components; three percent of cases were undetermined (including cases still under investigation and those who died before being interviewed); and one percent were diagnosed in persons with hemophilia/coagulation disorder.



*All cases reported to CDC with date of diagnosis prior to 1981.

**Cases reported to CDC by 12/26/88.

Note: Many cases diagnosed in 1988 will not be reported until later in 1989.

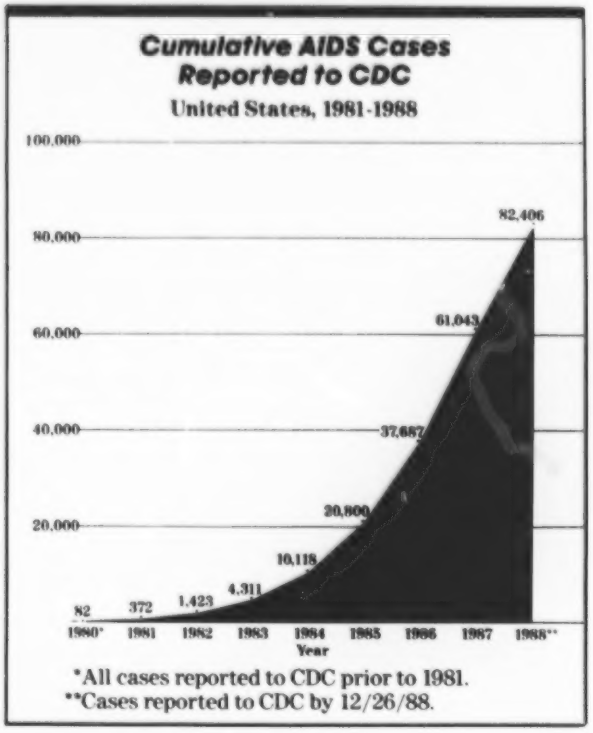
The U.S. Public Health Service (PHS), of which CDC is the agency responsible for epidemic investigations and disease reporting, estimates that between 1 and 1.5 million persons in the U.S. are infected with HIV, the AIDS virus. Many of those now infected will not show symptoms for several more years. The PHS has projected that, by the end of 1992, the U.S. will have a cumulative total of more than 365,000 cases of AIDS. It also projects that more than 80,000 new cases will be diagnosed in 1992 alone, mainly in people infected in 1988 or before. By the end of 1992, a cumulative total of 263,000 deaths are projected, with 66,000 occurring in 1992 alone. Projections extended to 1993 estimate 450,000 cumulative cases, with 100,000 new cases reported by the end of that year. The World Health Organization has estimated that five to 10 million people are infected with HIV and that by 1991, 50 to 100 million persons may be infected worldwide.

Since 1981, when AIDS was first recognized in the U.S. and the CDC started collecting data, the predominant number of cases has been among homosexual and bisexual men. But the number of cases among IV drug abusers has climbed rapidly, especially since 1986. In some places, the number of newly diagnosed cases due to IV drug abuse (or sexual contact with an IV drug abuser) is outpacing the number of cases diagnosed among homosexual men. This may be due in part to risk-reducing behavior changes among homosexual men. The PHS projects that by 1991, heterosexual transmission will account for at least one in every 20 cases of AIDS.

Some of the highest rates of new AIDS cases are found in the Hispanic and black communities. Although blacks make up 12 percent of the U.S. popula-

tion, 27 percent of reported AIDS cases are among blacks (until December 1988, blacks made up 26 percent). Fifteen percent (up from 14 percent in June 1988) are among Hispanics, who represent seven percent of the U.S. population.

The majority of reported cases of AIDS have been in large urban areas on the East and West Coasts. The New York City, San Francisco, Los Angeles, Houston, Newark, Washington, D.C., and Miami metropolitan areas lead the country in reported cases. But by 1991, says the PHS, 80 percent of AIDS cases will be found outside of those cities that currently report the greatest number of cases.



*All cases reported to CDC prior to 1981.
**Cases reported to CDC by 12/26/88.

Implications for Schools

HIV infection first and foremost is a medical problem, but it entails a host of other problems — social, moral, ethical, legal, fiscal — with numerous and complex implications for the entire community, including schools.

Discrimination and social conflicts, including those related to jobs, housing, and civil rights, have resulted from misinformation and unnecessary fear over the risk of HIV transmission. For schools, the most pressing issues have been the rights of HIV-infected students to attend school and of HIV-infected employees to continue working.

Federal laws, state regulations, and school district policies have protected the rights of students with AIDS or HIV infection to attend school. The few exceptions have been based on individual behavioral or medical conditions. Teachers and other school employees with AIDS or HIV infection generally have received job protection through federal and state laws that protect the rights of handicapped people.

School boards are advised to adopt policies on employment and school attendance of HIV-infected persons and on hygienic procedures to reduce the small theoretical risk of disease transmission within schools. To ensure that these policies are medically and legally sound, they should be developed with guidance from those with expertise in the medical and legal aspects of HIV infection. A policy adoption process that enables employees, parents, students, and other community members to have input to the policies can provide opportunities to educate the school community about HIV infection and result in increased acceptance of the presence of HIV-infected persons.

Increasingly, schools will feel pressure to provide HIV education to students. The importance of schools in educating young people about prevention of HIV infection is supported at the federal and state levels, among national education, parent, and youth organizations, and by the medical community.

Federal Actions on HIV Education

Initiatives by the federal government have provided guidance and support for increasing the number of schools in which HIV education is taught. In June 1987, the President appointed a 13-member commission composed of representatives of the medicine and health professions, business, religion, journalism, and politics to study the HIV epidemic. The commission, which was chaired by Admiral James D. Watkins, released a 200-page report in June 1988 containing hundreds of recommendations to fight the epidemic. The report addresses issues such as education, discrimination, confidentiality, and testing for HIV infection (see box).

Presidential Commission: Recommendations for HIV Education

In its June 1988 report, the Presidential Commission on the HIV Epidemic presented recommendations for HIV education. These include:

- State departments of education should take the lead in coordinating HIV-related educational initiatives within each state.
- Education plans should be aimed at the specific needs of individual communities and developed in conjunction with public health officials and community organizations and leaders.
- Schools should immediately introduce K-12 HIV education programs and develop comprehensive health education programs.

Until 1987, HIV education programs in schools generally were funded by local school districts, state education departments, and state and local health departments. In response to calls for greater leadership in educating the public about HIV, the federal government awarded $11.2 million in 1987 for school programs, administered through the CDC. In 1988, almost $30 million has been appropriated for school programs through the CDC's Division of Adolescent and School Health.

The federal Office of Disease Prevention and Health Promotion and the CDC funded the National Adolescent Student Health Survey, which polled

11,000 eighth and tenth-grade students in 1987. Questions about HIV were included in this national survey.

An additional federal action was the publication in October 1987 of *AIDS and the Education of Our Children: A Guide for Parents and Teachers* by the U.S. Department of Education (an updated edition was published in January 1988). The 28-page guide discusses facts about AIDS, what can be done to help protect children from AIDS, and information sources.

Education Initiatives by States

Some school systems, particularly those in cities where the HIV epidemic so far has hit hardest, have had HIV education programs in place for several years. Increasingly, state and local HIV education programs and policies are being prompted by state legislation or regulations.

In June 1987, only five states required schools to teach about AIDS and HIV prevention. One year later, the report of a survey conducted by the Council of Chief State School Officers (CCSSO) revealed that 24 states had mandates for HIV education. The recommendation by the Presidential Commission on the HIV Epidemic that state boards of education require HIV education at all school levels soon could boost the number of states that have mandates.

What Are States Mandating?

State mandates for HIV education vary. In Rhode Island and New York, HIV education is supposed to be part of every school system's comprehensive health education program. In Ohio and Iowa, HIV education is to be included in instruction about sexually transmitted diseases (STDs). Nevada and Kansas include it in sex education. HIV instruction is taught as a communicable disease in North Carolina, as part of a general health curriculum in Pennsylvania, and by itself in Oklahoma, Alabama, and Maryland. Kentucky and Virginia require family life education, including instruction on HIV, in grades K-12.

The majority of states and the District of Columbia mandate that HIV education begin at a specific grade level—in most cases, grades six or seven, according to information from the CCSSO. All of the states with mandates have developed instructional materials, program guidelines, or teacher's guides for HIV instruction. Alabama, Delaware, the District of Columbia, Hawaii, Louisiana, Missouri, Oklahoma, Rhode Island, and Virginia have mandatory HIV curricula.

Efforts of National Groups

National organizations funded by CDC are developing programs to encourage their members and others to increase the number of schools providing HIV education, improve the effectiveness of those efforts, and integrate HIV education within more comprehensive programs of school health education.

Through its CDC-supported project, for example, NSBA is developing a training program for board members to help them maintain up-to-date information about HIV and effective HIV-education approaches, as well as to develop the leadership, management, and public relations skills they will need for dealing with controversial subjects. This report is part of the NSBA project.

Other national organizations are developing similar programs. School board members should be aware that these and other organizations seek to help their respective members propose, develop, and consistently improve HIV education programs. School boards may find their communities ready with ideas and already conditioned for beginning HIV education.

National Organizations Funded by CDC

- American Association of School Administrators
- American College Health Association
- American Federation of Teachers
- American Medical Association
- American School Health Association
- Association for the Advancement of Health Education
- Center for Population Options
- Council of Chief State School Officers
- ETR Associates
- National Association of State Boards of Education
- National Coalition of Advocates for Students
- National Coalition of Hispanic Health and Human Services Organizations
- National Commission on Correctional Health Care
- National Education Association
- National Network of Runaway and Youth Services
- National Organization of Black County Officials
- National PTA
- National Rural and Small Schools Consortium
- National School Boards Association

Action by the Private Sector

A growing number of private sector and philanthropic organizations are funding HIV education projects. For example, the Robert Wood Johnson Foundation in Princeton, N.J., the nation's largest health care philanthropy, is funding a variety of community-based prevention and service projects. The foundation already has awarded more than $20 million for HIV-related efforts. In August 1988, the U.S. Conference of Mayors provided in its newsletter, *AIDS Information Exchange*, a list of funding sources for HIV activities.

The American Council of Life Insurance and the Health Insurance Association of America are distributing a brochure titled "Teens & AIDS: Playing It Safe." A number of school systems work with private community organizations in providing school programs on AIDS. The San Francisco Unified School District, for example, works with the San Francisco AIDS Foundation on a parent involvement program.

Cooperation and Collaboration Are Needed

Public health officials stress that the combined efforts of federal and state governments, schools, local agencies, and local and national organizations are needed to combat the spread of HIV. Because the threat is so great and so complex, schools are encouraged to work with parents, community agencies, public health departments, and others in providing HIV education so that efforts will be comprehensive, resources will be used effectively, and information will be consistent, complementary, and reinforcing.

CDC's HIV Education Programs

The CDC's Program for School Health Education to Prevent the Spread of HIV uses six systems:

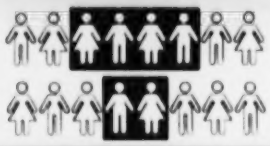
- Cooperative agreements with 19 national organizations (including NSBA) involved in the education and health of youth;
- Cooperative agreements with 54 state and territorial education agencies and 16 local school districts in areas with the highest cumulative incidence of AIDS;
- Training/demonstration programs;
- Development and dissemination of model HIV curricula and materials;
- Survey research to assess HIV-related knowledge, beliefs, and behaviors among adolescents over time; and
- Evaluation research on the effectiveness of school programs in HIV prevention.

These programs are intended to help schools implement HIV education immediately and to assist in integrating HIV education into more comprehensive programs of school health education.

The CDC has developed a computerized database so that educators have access to a wide variety of HIV education materials. As of Fall 1988, this database, which is part of the Combined Health Information Database (CHID), contained more than 240 abstracts of HIV curricula, policies, teaching materials, and program descriptions. Also, through a contract with CDC, the Education Development Center, Inc. of Newton, Mass., is integrating HIV information into two existing comprehensive school health curricula, *Growing Healthy* and *Teenage Health Teaching Modules* (THTM).

In January 1988, the CDC published "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" (a 14-page supplement to CDC's *Morbidity and Mortality Weekly Report*, January 29, 1988, Vol. 37, No. S-2), recommendations from which are included in ensuing sections of this report. NSBA was one of 15 national organizations that helped develop these guidelines. Included in the guidelines are the President's Domestic Policy Council's principles for AIDS education.

The CDC also is establishing a National Agenda for Behavioral Research to Control the AIDS Epidemic. In cooperation with the National Institute on Drug Abuse, the National Institute for Child Health and Human Development, and the National Institute on Mental Health, the CDC is funding a National Academy of Sciences study on behavioral research related to the AIDS epidemic.



CHAPTER I
THE IMPERATIVE FOR HIV EDUCATION

The future for those who engage in risky behaviors is uncertain at best. Because the latency period for developing symptoms of AIDS can be measured in years, the vast majority of persons projected to develop AIDS by 1991 already are infected. According to the *Surgeon General's Report*, however, 14,000 of the AIDS deaths projected for 1991 could be prevented with the proper information and education.

Education to prevent HIV infection should focus on people who practice risky behaviors, including school-age youth, says Surgeon General Koop: "Education about AIDS should start in early elementary school and at home so that children can grow up knowing the behavior to avoid to protect themselves from exposure to the AIDS virus."

Dr. Koop notes that "the threat of AIDS can provide an opportunity for parents to instill in their children their own moral and ethical standards." But the schools also must help protect students, he says. Educators and others "cannot disregard this responsibility to educate our young. The need is critical and the price of neglect is high. The lives of our young people depend on our fulfilling our responsibility."

Reinforcing the Surgeon General's message that education is the most effective means available for controlling the epidemic is the Institute of Medicine/National Academy of Sciences (IOM/NAS) AIDS committee. The IOM/NAS 1986 report, *Confronting AIDS*, calls for "special educational efforts" to reach teenagers. The report notes that in 1980, before AIDS was recognized, the PHS established the goal of educating every junior high and high school student in the public schools about sexually transmitted diseases by 1990. With that deadline in mind, the impetus to teach students about STDs is many times more pressing now because of AIDS, and schools are obligated to provide health education that includes sex education and facts about AIDS "in terms teenagers can understand," says the report. In *Confronting AIDS: Update 1988*, the IOM/NAS committee emphasizes that school-based educational programs "should begin at a young age and have a level and explicitness appropriate for the age group."

The Threat to Young People

In his groundbreaking national report on AIDS, Surgeon General C. Everett Koop noted, "Adolescents and pre-adolescents are those whose behavior we wish to especially influence because of their vulnerability when they are exploring their own sexuality (heterosexual and homosexual) and perhaps experimenting with drugs. Teenagers often consider themselves immortal, and these young people may be putting themselves at great risk."

As they reach childbearing age, teenagers may be putting more than themselves at risk. According to the 1986 study, "United States and Cross-National Trends in Teenage Sexuality and Fertility Behavior," by the Alan Guttmacher Institute, a family-planning information organization in Washington, D.C., about 10 percent of teenage women get pregnant each year and 40 percent of women become pregnant before age 20. Increasingly, cases of AIDS are being diagnosed in infants and children born to women infected with HIV. As of October 17, 1988, there were 998 cases of AIDS in children aged five and under.

At the Fourth International Conference on AIDS held in Stockholm in June 1988, pediatrician and CDC epidemiologist Helene Gayle, M.D., presented evidence that young people are at risk of HIV infection, and that heterosexual transmission is a more significant factor for adolescents. Her report, "Demographic and Sexual Transmission Differences Between Adolescent and Adult AIDS Patients, USA," based on an analysis of CDC AIDS surveillance data collected by mid-1988, revealed:

- Nearly one percent of reported AIDS cases in the United States are diagnosed in people between the ages of 13 and 21.
- Six percent of all cases occur in persons between the ages 22 and 25, and the likelihood is that they were infected during adolescence.
- The proportion of females among adolescents with AIDS is greater than that among adults with AIDS (14 percent vs. 7 percent).
- The proportion of female adolescents who were infected through heterosexual contact is greater than that among adult females (9 percent vs. 4 percent).
- The proportion of male adolescents with AIDS attributable to homosexual or bisexual activity is smaller than that among adult males (49 percent vs. 65 percent).

"We don't know what the real prevalence of infection is," Gayle told those assembled in Stockholm. "But we do know the problem is much greater than case numbers would indicate, and it's something people need to start focusing on because changing the behavior of adolescents is going to make a big difference in terms of what we see."

Additional evidence that young people are at risk is provided by data from Department of Defense (DOD) studies. The DOD, which routinely has tested

military recruit applicants for HIV infection since 1985, has found that 1.4 out of every 1,000 recruits tests positive for exposure to the virus. In some locations, studies show much higher seropositivity (presence of antibodies to HIV). In metropolitan Washington, D.C., one in 100 applicants tests positive, and in New York City, one in 50. According to Major John Brundage, M.D., of the Walter Reed Army Institute of Research, DOD studies show prevalence of infection increases from age 18 to the mid-20s.

Also, since March 1987, new participants in Department of Labor Job Corps residential training programs have been required to undergo HIV antibody screening. Provisional data based on tests of 65,960 entrants show four of every 1,000 entrants to be HIV positive. Job corps entrants are young people between ages 16 and 21 and tend to represent the inner-city and rural poor.

An Educator's Call for Action

Perhaps one of the most eloquent arguments for HIV education has come from John Washburn, retired superintendent of Brighton (N.Y.) public schools. Washburn, who was diagnosed with AIDS in 1987, told school leaders at the 1988 annual conventions of NSBA and of the American Association of School Administrators that he intended to dedicate the rest of his life to helping young people avoid the agony and the premature death he faces.

"AIDS education is a must," he said. "Not to stop the spread of AIDS is to ensure death and dying for young people." Early and explicit education in the schools, Washburn emphasized, is "the only vaccine available" against HIV.

High Risk Factors for Adolescents

Several factors cause public health officials to be concerned that adolescents specifically are at risk of infection and of spreading HIV. These include:

Amount of sexual activity. Half of all teenage girls in high school have had sexual intercourse, and 16 percent report having had four or more partners, according to the Alan Guttmacher Institute. A nationwide poll conducted in 1986 by Louis Harris and Associates indicated that 57 percent of 17-year-olds have had sexual intercourse. The average age of first intercourse is 16, but this varies widely by community. A 1987 survey of students conducted by some state and local education agencies with assistance from the CDC revealed a range of 28.6 to 76.4 percent of students reporting at least one experience with sexual intercourse; for students aged 13 to 14, the range was 15.9 to 34.5 percent (*Morbidity and Mortality Weekly Report*, Dec. 2, 1988).

Lack of protection during sexual intercourse. Many teenagers do not use contraceptives. Some 1.5 million teenagers — or one in ten — become pregnant each year. According to a 1980 study published in *Family Planning Perspectives*, only one-third of sexually active teenagers use contraceptives regularly. Only 50 percent of teenage girls use contraceptives for their first sexual intercourse. Fewer than 25 percent of sexually active teens who use contraceptives use condoms, according to the National Center for Health Statistics.

Prevalence of sexually transmitted diseases (STDs). Some 2.5 million teenagers contracted an STD in 1987, according to the CDC. One in seven teenagers had such diseases as gonorrhea, herpes, chlamydia, venereal warts, and syphilis. In addition to the evidence of teenage sexual activity provided by these data, research scientists consider some STDs to be a significant factor relating to susceptibility to HIV infection.

Homosexual activity. Sexual experimentation by teenagers sometimes includes homosexual activity. Research in this area is considered incomplete, and the actual incidence of homosexual activity among adolescent males is not known. But risky sexual behavior, such as anal intercourse, places some young men at particular risk of HIV infection. Writing in the *Journal of the American Medical Association* (July 10, 1987), Gary Remafedi, M.D., M.P.H., stated, "Today's adolescents, who are not yet infected by human immunodeficiency virus and who are newly exploring their homosexual life-styles, are among those persons most likely to benefit from preventative efforts." To be most effective, therefore, HIV education programs should avoid being sexist or judgmental regarding sexual orientation.

Sexual abuse. The true incidence of child abuse is not known, but an estimated 250,000 to 500,000 children are sexually abused each year, according to a 1985 study by the Division of Maternal and Child Health, U.S. Department of Health and Human Services. Research demonstrating a link between homosexual behavior or IV drug abuse to child sexual abuse is scant. In *A Look at Child Sexual Abuse* (National Committee for Prevention of Child Abuse, 1986), however, author Jon R. Conte of the University of Chicago writes that awareness is increasing that children who are sexually abused may be at risk for STDs. HIV, like other sexually transmitted organisms, may infect children through sexual abuse.

Homeless youth. An estimated one million teenagers run away or are "pushed out" of their homes each year, according to the National Network of Runaway and Youth Services, Inc. Many of these youth become involved in illegal drugs and prostitution. As many as 200,000 teenagers are involved in prostitution each year, according to the "Fiscal Year 1985 Study of Runaways and Youth," U.S. Department of Health and Human Services. A study by the N.Y. State Department of Health and Covenant House, a private social welfare agency in New York City, which was presented at the November 1988 annual meeting of the American Public Health Association, found that seven percent of homeless teenagers in New York — 1,500 of the estimated 20,000 such youth — are infected with the AIDS virus.

Drug abuse. Data published in *Morbidity and Mortality Weekly Report* (Dec. 2, 1988) indicate that IV drug abuse among teenagers may be more common than previously thought. During 1987-88, surveys of approximately 10,000 high school students about HIV-related behaviors (IV drug use and sexual inter-

course) were administered by three state education departments and one urban school district. Responses revealed that the percentage of students who reported ever injecting cocaine, heroin, or other illegal drugs ranged from 2.8 to 6.3 percent; more males (ranging from 3.4 to 8.7 percent) than females (ranging from 2.1 to 4.6 percent) reported this behavior, and the injection of illicit drugs was found to be more common among 17- to 18-year-olds (ranging from 1.3 to 8.9 percent) than among younger students (1.4 to 3.2 percent for 13- to 14-year-olds, and 3.2 to 4.0 percent for 15- to 16-year-olds).

The significance of these data is underscored by data from other studies that show a steady increase in the use of cocaine, which can be injected. Some seven percent of high school seniors reported using cocaine in 1985, according to *U.S. Children and Their Families: Current Conditions and Recent Trends, 1987*, a report of the Select Committee on Children, Youth, and Families, U.S. House of Representatives.

In addition to the high risk of HIV infection associated with intravenous drug abuse, substance abuse lowers inhibitions toward risky sexual behavior and can lower the body's immune responses. Although drug and alcohol abuse among adolescents in general has declined in recent years, some 26 percent of high school seniors in 1985 reported having used marijuana, and some 66 percent reported experience with drinking, according to the 1985 Select Committee report. Some 13 percent of seniors in 1986 reported that, within 30 days of their participation in an annual survey conducted by the University of Michigan's Institute for Social Research, they had used an illegal drug other than marijuana.

Other potential risks. Additional possible modes of transmission of HIV through infected needles include piercing ears, tattooing, and injecting steroids, notes *AIDS and Adolescents*, a 1987 Center for Population Options (CPO) publication.

Reaching Those Most at Risk

Some teenagers are at greater risk of HIV infection than others because of an increased probability that they will engage in risk behaviors or because of an increased prevalence of HIV infection in their communities. Young people may be more likely to engage in risk behaviors in communities where IV drug abuse is common and where many teenagers become sexually active at a young age. In such communities, the prevalence of HIV infection may be or has the potential for being high, thus increasing the risk.

In a speech to the National Association of Elementary School Principals' state leadership in July 1987, Surgeon General Koop noted that "in some parts of urban America, the task [of stopping the spread of HIV] is complicated by the fact that your juvenile charges come from settings where older siblings and others with whom they live are disadvantaged, with low socioeconomic status, low educational level, a sense of powerlessness and helplessness, are unemployed and perhaps abusing drugs. From the point of view of AIDS prevention, such environments present us with the greatest challenge. . . ."

An Innovative Program

The Adolescent Pregnancy Prevention Program run by the Children's Aid Society in New York City has helped more than 200 teenagers stay HIV-free, pregnancy-free, enrolled in school, and employed during the four years it has been in existence in Central Harlem. The program focuses on raising the self-esteem of students through counseling, academic help, medical care, family life and sex education, medical services, sports, performing arts, and guaranteed admission to college. "Success in school, the presence of caring adults, and work and having a dollar in your pocket all are contraceptive," says Michael A. Carrera, director of the program and a professor of health sciences at Hunter College.

Teaching young people who live in risky environments about HIV prevention, like teaching about pregnancy prevention, is a complex undertaking, says Carrera. You can't tell kids to abstain or delay for the sake of the future. "You have to relate the message to the present and let them know you're there [to help them] for the long haul."

Misconceptions Exist Among Adolescents

A 1985 study of 1,332 students aged 14 to 18 in ten San Francisco high schools indicated that although 92 percent knew that sexual intercourse is one mode of becoming infected with HIV, only 60 percent knew that using a condom during sexual intercourse decreases the risk of spreading the disease. One-third believed a person could contract the virus merely by using an infected person's personal belongings, such as a comb, or by casual contact, such as shaking hands. Fewer than half (41 percent) knew that kissing was not a route of HIV transmission. Nearly three-quarters (74 percent) reported being worried about contracting the disease.

Increased education about HIV transmission may help clear up misconceptions, but the results of the National Adolescent Student Health Survey (NASHS), reported in August 1988, reveal that misinformation persists among young people. NASHS, a survey of more than 11,000 eighth and tenth-grade students conducted in 1987, found that 71 percent of those surveyed believed that blood transfusions are a common way to be infected with HIV today, 47 percent believed that there is an increased risk of HIV transmission when donating blood, and 51 percent were either unsure or mistakenly believed that washing after sex reduces one's chance of being infected with HIV.

But NASHS revealed some good news, too. Of those surveyed, 94 percent knew there is increased risk of HIV infection from having intercourse with someone who is infected with the virus, and 91 percent knew that sharing drug needles increases the risk of HIV infection. Adolescents also knew (86 percent) that condoms are an effective way to reduce the risk of HIV infection; 91 percent agreed that adolescents should use condoms if they have sexual intercourse.

Although surveys like NASHS have revealed that a large proportion of adolescents need more informa-

tion about HIV, fortunately, there also is evidence that these young people want more information. In 1987 a Massachusetts survey of 16- to 19-year-olds revealed that the vast majority of respondents (97 percent) thought information about HIV infection should be available in schools. More than half (57 percent) reported that HIV infection had been discussed but not taught by a teacher in their schools; the same percentage believed that there was not enough information available to teenagers about HIV infection.

An example of the desire young people have for more information about HIV is indicated by the usage of an AIDS hotline by teenagers in Montgomery County, Md. From February through May 1987, trained student volunteers at the the Teen AIDS Hotline, the nation's first operated by and for teenagers, fielded more than 4,000 telephone calls about AIDS symptoms, HIV antibody testing, and sexual practices, according to an article in *The Washington Post*. *The New York Times* reported that a toll-free hotline for teens in Kansas City, Mo., received on average 1,000 calls a month since it began operating in April 1988.

The Role of Schools

A survey of 73 of the largest U.S. school systems and 25 state education agencies conducted by the U.S. Conference of Mayors in December 1986 indicated that 54 percent provided some form of HIV instruction, and that a majority of those that did not were planning to provide HIV education. The Presidential Commission on the HIV Epidemic supported those efforts in its June 1988 report by calling for more school-based HIV education.

The Commission report said that HIV education in the schools "is of vital importance and must be introduced across the nation immediately." Decisions about the appropriate content and methods of instruction "should be determined at the local level. However, both elementary and secondary school students should receive such education," said the Commission. By ensuring that appropriate education about HIV is provided throughout the elementary and secondary school system, "we can help our younger generation avoid the tragedy we are witnessing today."

But some school districts are hesitant about providing HIV education. HIV infection is a controversial issue. It forces people to deal with their attitudes and beliefs about sexuality (including homosexuality and sex outside of marriage), substance abuse, and the role of the schools in teaching about these subjects. Even basic sex education about reproduction — if it is offered at all — is cursory in many schools. For example, in 1987, only nine state statutes permitted or mandated education programs about sexually transmitted diseases. Only 10 percent of K-12 public school students received school-based education about sexuality, according to the Sex Information and Education Council of the U.S. (SIECUS), a New York based clearinghouse.

Yet the public supports sex education and HIV education:

- 70 percent of respondents in a November 1987 *Newsweek* poll said they approved of sex education.
- 95 percent of adults participating in a 1987 NBC poll approved of teaching HIV prevention to children in public school.
- Nearly 75 percent of Texans questioned in a February 1987 poll conducted by Texas A&M University's Public Policy Resources Laboratory said they favored sex education in grade school to help combat the spread of HIV, and 74 percent supported more sex education in grade school, including instruction on STDs and the use of condoms.
- A 1987 national Gallup poll indicated that more than 80 percent of Americans thought HIV, venereal diseases, and birth control should be covered in high school classes; about 50 percent would have included these topics in elementary school programs.
- The 1988 national Gallup poll found that 90 percent of those sampled supported HIV education in schools; among public school parents, 94 percent said that schools should provide such education.

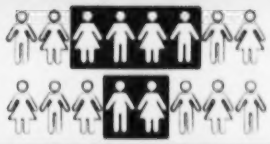
By supporting school-based HIV education, parents are not abdicating their role in educating their children. Recent polls of adults have shown that more parents are discussing AIDS and the prevention of HIV infection with their children. A November 1987 survey of 3,333 adults by the National Center for Health Statistics showed that 68 percent of the adults who said they had children between the ages of ten and 17 had discussed HIV infection with their children. This figure represents an increase of eight percent over a similar poll taken in August 1987. The November survey also showed that 51 percent of the adults who had children said their children had received instruction about HIV in school, reflecting a 15 percent increase from August.

Public Support for Sex Education and HIV Education

	Percentage Approving
Sex Education	
Newsweek	70%
Texas A&M	74%
HIV Education	
NBC	95%
Gallup (1987)	
in high school	84%
in elementary school	58%
Gallup (1988)	
general public	90%
public school parents	94%

Clearly, reaching young people with the HIV prevention message requires more than classroom in-

struction. Public health officials and educators advise that, to be effective, HIV education programs must reach out to the community at large to enlist parental support and the community's help in fighting the spread of HIV. School programs must educate school people — teachers, administrators, school board members, and other staff members and officials — and the broader school community of parents, public officials, and other local agencies, so that HIV education in schools is consistent with community values and needs and is reinforced by parents within the context of family values.



CHAPTER II
THE PROMISE OF HIV EDUCATION

The results of a 1987 study of sexually active San Francisco youth reported in the *American Journal of Public Health* (April 1988) show that knowledge alone will not have desired effects on adolescent behaviors. Having received school-based sex education and having been exposed to numerous public health media messages, the adolescents in this study reported that they were aware that condoms reduce the risk of STDs. Nevertheless, these San Francisco youth continued to have sexual intercourse with multiple partners and did not substantially increase their use of condoms.

Educators know that translating health knowledge into healthy behaviors is no simple task. Yet effective strategies do exist.

HIV Education Must Focus on Behaviors

During adolescence, teenagers are exploring their sexual identities, often feel immortal and invulnerable, tend to think concretely about the present, and have difficulty thinking about risks to their futures. If behavior is to be modified, programs designed to teach young people how to avoid HIV infection must take into account not only their level of knowledge but also their attitudes, beliefs, skills, and behaviors.

Public health officials and educators advise that, to address these issues, HIV education programs must be based on knowledge of their target audiences. With adolescents and pre-adolescents, HIV programs must be sensitive to the developmental stage of these young people, to the influence of peer pressure (to have sexual intercourse, to use drugs, and so on), and to their disregard for authority. They also must take into account what information students have learned in earlier health education or family life classes, as well as the misinformation they may have acquired. Instruction should focus on concerns of adolescents, involving them in teaching about the risks among young people, as well as dispelling perceptions that HIV infection is a problem only among certain groups.

Effectiveness of Health Education

Public health officials are optimistic that an appropriate education program may change behavior. Carefully evaluated comprehensive health education has been effective in reducing smoking and influencing other health-related behaviors.

The School Health Education Evaluation (SHEE), as reported in the *Journal of School Health* (October 1985), provides convincing evidence based on a study that involved 30,000 children in grades 4 to 7. The study revealed that overall knowledge, attitudes, practices, and program-specific knowledge could be positively affected through the cumulative impact of school health education.

Commitment to program implementation, including provision of teacher in-service, administrative support, materials, and classroom time devoted to health education, suggested a relationship to success in meeting a program's objectives. The analysis of the relationship of class hours, for instance, revealed that knowledge could be affected through relatively few hours, but that significant time commitment (40 to 50 hours) is necessary to result in stable effects on attitudes and practices.

The success of a school and community-based health education program in reducing the pregnancy rate among unmarried adolescents in a South Carolina county also suggests that young people's behaviors can be changed. The program, which integrates sex education and focuses on helping students develop decision-making and communication skills and self-esteem, is considered responsible for lowering the teenage pregnancy rate significantly. From 1981 to 1985, the program was implemented with the involvement of the schools, parents, teachers, religious and community leaders, and students. The number of pregnancies was reduced by more than half, compared to a significant increase in the number of pregnancies in surrounding counties.

Comprehensive Health Education

Because of the need for expediency in fighting the spread of HIV among young people, some school systems teach about HIV during a single class or special school session designed to give students the basic prevention facts quickly. For example, educators might show a film or videotape, have the school nurse or physician or a guest speaker talk about HIV transmission and prevention, and perhaps have a question and answer period. This approach appears to be particularly common in schools which do not have a comprehensive K-12 health education curriculum.

Most educators agree that providing instruction on HIV prevention as a stand-alone program is acceptable if it is the *only* way that students will have access to current, accurate information on HIV and the risks they face. But such single shots at educating students cannot provide sufficient depth of information nor opportunities for students to explore various

aspects of the disease, its transmission, and its prevention, say many educators. The CDC's guidelines for HIV education note that "a single film, lecture, or school assembly about AIDS will not be sufficient to assure that students develop the complex understanding and skills they will need to avoid becoming infected."

Some school systems, as a preliminary step to a more comprehensive approach, have arranged special assemblies or lectures in an effort to get information about AIDS and HIV to a specific group of students they believe might be at high risk of infection. These might be high school students before the onset of summer vacation, or seniors about to graduate.

In the spring of 1987, all intermediate and high schools in Pasadena, Texas, held assemblies that included a film, a presentation by a school nurse, and a question and answer period. That summer, however, the schools developed a course of studies on HIV that was integrated more smoothly into the existing social studies, biology, science, health, and home economics curricula during the 1987-88 school year, after teachers had received in-service training.

Many educators agree that the best way to present information about HIV and AIDS is within the context of a comprehensive and sequential health education curriculum that includes, for example, education about the relationship between behaviors and health, about how to resist persuasion, and about sexual reproduction, sexually transmitted diseases, and substance abuse.

"You can't teach about AIDS in a vacuum," says Michael I. Grady, M.D., medical director for the Boston Public Schools. "It must be part of a comprehensive program." Because HIV is transmitted through sexual intercourse, HIV prevention programs could run into problems in schools that haven't taught the basics of sex education, says Irvington, N.J., educator Claire Scholz: "What does a teacher say when a child asks about homosexuality or sexual intercourse?" And Susan Wilson of the New Jersey Network for Family Life Education and a former member of the state board of education says teaching children about HIV before teaching about sex as a natural, healthy body function makes children fear sex and "destroys adults' credibility."

Stephen Sroka, an eighth grade health teacher in Cleveland who developed one of the nation's first AIDS curricula, *Educator's Guide to AIDS and Other STDs*, describes how HIV can be incorporated into the family life component of health education: In grades K-4, HIV instruction focuses on traditional family values, simple body systems, the concepts of healthy bodies, wellness, and disease prevention. In grades 5-6, the instruction includes body systems, menstruation, sexual intercourse, and some specifics about sexually transmitted diseases and HIV. In grades 7-8, instruction about HIV becomes more specific and includes discussion about homosexuality.

High-level Support for Comprehensive Health Education

Surgeon General Koop has said that teaching about HIV should be part of a comprehensive K-12 health or family life education program. The CDC school guidelines also recommend that HIV education be integrated into a more comprehensive program of school health, a sequential program that is provided "at each grade level to assure that students acquire essential knowledge appropriate for that grade level, and have time to ask questions and discuss issues raised by the information presented." In its June 1988 report, the Presidential Commission on the HIV Epidemic recommended that by the year 2000 all schools have fully implemented comprehensive health education programs for grades K-12.

CHAPTER III
OVERCOMING BARRIERS TO HIV EDUCATION

The HIV epidemic is forcing people to confront their feelings about a number of sensitive subjects — sexuality and certain sexual practices, homosexuality, bisexuality, drug abuse, cancer and other life-threatening diseases, and death. But there has been a rapid evolution in the nation's ability to come to terms with AIDS and HIV infection. The mass media, educators, and many of the rest of us now talk frankly about HIV, how it is transmitted, and how it can be prevented.

People are becoming more accustomed to frank discussion and polls indicate that most Americans approve of HIV education in schools. Nevertheless, such instruction still might not be accepted easily in some communities for a variety of reasons. School board members and school administrators should be prepared for controversy and, moreover, should plan how they will overcome potential barriers to HIV education before attempting to introduce a school program. Identifying potential barriers is the first step.

Apathy Toward HIV Education

Educators cannot take for granted that everyone in their community is aware of the threat of HIV and, particularly, of its threat to young people. Even when they realize that lives are at stake, some people may not acknowledge or agree that prevention programs are necessary or appropriate for their community's schools. As one HIV curriculum specialist put it in an article in *The American School Board Journal*, "People don't want to touch this with a ten-foot pole. It's about understanding sexual behavior. [And] a lot of it is foreign to them."

"We think AIDS is the biggest public relations problem we've ever encountered," says John Wherry, executive director of the National School Public Relations Association in Arlington, Va. "We have to get people talking about it first." To persuade people who might not believe HIV could threaten the young people in their community, schools need a public relations plan "that says who needs to know [about AIDS and HIV] and how the schools are going to handle" the education of the community in preparation for a school program.

Misinformation and Media Hype

National polls have shown that many people are misinformed about the means and risks of HIV transmission. People need access to detailed information about HIV transmission to be convinced that they can't be infected by casual contact and that HIV infection is preventable. By informing the community about what HIV instruction will entail, schools can provide the public with critical information about the disease.

Another problem is sensational, unbalanced, or incomplete news coverage about how local schools are approaching HIV education. HIV is an emotional wick, a subject that draws newspaper readers and television viewers. If newspaper coverage, for example, focuses first on the fact that a school program includes references to condoms as a preventive measure or that it includes discussion of anal sex as a high-risk behavior, school officials could face immediate objections.

Before releasing any specific information about what a program will or will not include, it's best for the board, along with school administrators and staff, and experts such as local health professionals, to determine how the more controversial aspects of the program will be put into the context of an overall program that is educationally sound and in keeping with community values — with the help of the media.

New Information

Along with countering misinformation, educators must keep abreast of new findings and developments related to the virus and its effects. To maintain a program's credibility, and to assure that students are getting the best available information, teachers, administrators, and board members should make a point of reading regularly about HIV and AIDS (a list of resources is at the end of this report). School boards should ensure that instructional staff have direct access to the local or state department of health, the most appropriate sources of accurate information.

Moral and Religious Concerns

HIV education may be a primary target for attacks by individuals and groups who object to the discussion of sex, condoms, or even decision making, in the public schools. Some groups may express concerns over the level of specificity, the grade level at which instruction should start, and the amount of emphasis on abstinence.

Parents and others might be concerned that their values will be challenged in HIV instruction, or that religious edicts will be contradicted. As groups and individuals become more informed about the urgency of HIV prevention, however, they may

provide leadership for programs that incorporate respect for their values.

For example, a recent policy paper by the nation's Roman Catholic bishops took the position that students in Catholic schools could be taught that condoms offer protection against HIV. In keeping with the Church's positions against sex outside of marriage and against the use of birth control devices, the paper says that "the only morally correct and medically sure ways" to prevent HIV infection are "abstinence outside of marriage and fidelity within marriage, as well as the avoidance of intravenous drug abuse." The bishops added, however, that HIV education programs also might include information about condoms because society is pluralistic, and "some people will not act as they can and should."

School leaders should be aware that other organized religions have issued statements of support for HIV education. In many communities, local clergy will be strong allies of schools in promoting support for HIV instruction; assistance in dealing with religious objections also can be sought from state and national religious organizations. The National Council of the Churches of Christ, for example, distributes a summary of the policy statements of the various denominations that have recognized the imperative for HIV education and compassion and support for HIV-infected people.

Concerns About Homosexuality

Because AIDS was first diagnosed among homosexual men, early on it was referred to as the "gay plague." Although the medical community has shown that HIV is transmitted through risk behavior rather than as the result of a specific sexual orientation, some people persist in believing that all homosexual people have AIDS or are infected with HIV and are to be feared or ostracized. Some people even see HIV infection as a retribution for sexual practices that their own moral or religious codes prohibit.

School officials should be aware that resistance to HIV education could arise from concerns and fears about addressing homosexuality in the classroom. Parents may be unwilling to acknowledge the possibility that their adolescent children may experiment with homosexuality. On the other hand, many young people believe incorrectly that they are immune from infection if they are heterosexual; HIV education programs in the schools can clarify that behaviors, not lifestyles, put people at risk.

Not to be ignored are students who consider themselves to be homosexual and those students who have a homosexual family member or friend. These young people need to have their questions answered in a climate in which the message is reinforced that it is not who you are that puts people at risk of HIV infection, but what you do.

Attitudes About Sexuality

For most people, sexuality is a private matter. Even discussing a school program might be an uncomfortable experience if the program includes specific sex-related information. In spite of polls showing that most parents want their children to receive sex education and that few parents talk to their children about sex, some parents believe that the subject should be handled only in the home.

Part of this belief may stem from the desire not to have their children learn about sexual practices of which their parents don't approve or from the belief that their children will be more inclined to experiment with sex after learning about it in school. Other adults simply may not feel they know enough about sexuality or HIV to teach their children.

In providing HIV education, school officials must emphasize that parents are the primary sex educators and that the school program seeks to support them. Schools also can emphasize that HIV education, like sex education in general, can help dispel misinformation about sex, such as television or print ads that suggest all teenagers are having sex, explains Susan Wilson, executive coordinator of the New Jersey Network for Family Life Education. Many parents are not aware of how much their children know about sex, she says, and education on HIV and sexuality can be "an antidote to media bombardment with sexual messages. It helps kids process those messages."

Uncertainty About Appropriate Instruction

Along with concern over what will be discussed, parents, other community members, and perhaps school staff members might be concerned about the age level at which students will learn about HIV. Some educators believe that discussing HIV in the context of sex and drugs should begin at about the fifth grade level. The 1988 Gallup Poll of public attitudes toward public schools asked those who supported public school education about HIV (90 percent of all respondents) at what age students should begin receiving such instruction. The results showed that 86 percent of this group thought that HIV education should begin before age 13 (see box, page 17).

Most HIV and health educators agree that instruction about HIV transmission and prevention should begin no later than grade seven because many young people already are beginning to experiment with sex and drugs — or at least are thinking about it. Because children are curious and sometimes fearful about AIDS, many educators believe that young children should be told about the disease in terms they can understand. "We've found out from parents that very young children know about AIDS, and when they come down with colds, they are worried they have AIDS," notes Judi Mollerus, school/community relations coordinator for the Minnetonka (Minn.) Public Schools.

The content of HIV instruction should be appropriate for the students' developmental level and should be consistent with community values and needs. For example, instruction in the primary grades (K-3) should focus on communicable disease and on assuring children that HIV is difficult to catch, rather than on sex or drug abuse.

Many health educators advise that appropriate HIV education should be integrated into a kindergarten through 12th grade comprehensive program of school health education, a program that addresses the knowledge, skills, and support young people

need at appropriate developmental levels. Such education is sequential and repeated throughout the young person's schooling. It provides the student with both a foundation for understanding the relationship between health and behavior and the skills to prevent HIV infection and other health problems.

*1988 Gallup Poll Results**

The Gallup Poll asked those who favored having local public schools develop an HIV education program (90 percent of all respondents) the following questions:

At what age should students begin participating in an HIV education program?

	National Totals	Public School Parents	NonPublic School Parents
	%	%	%
Under 5 Years	6	5	11
5-9 years	40	43	42
10-12 years	40	39	32
13-15 years	10	11	13
16 years or older	1	1	1
Don't know	3	1	1

Should the local public schools teach what is called "safe sex" for HIV prevention, or should they not? *(This was understood to mean teaching about the safe use of condoms.)*

Should	78	81	82
Should not	16	16	15
Don't know	6	3	3

*From the *20th Annual Gallup Poll of the Public's Attitudes Toward the Public Schools.*

Concern About Degrees of Specificity

Another major source of disagreement is how frank HIV instruction should be. Because of potential objections over discussing condoms, anal and oral sex, and other sensitive topics, even HIV program specialists acknowledge there are no rules on specificity.

Some argue for being specific, including discussion of high-risk sexual practices such as anal intercourse. "Kids are guilt ridden," according to one curriculum specialist. "If we say sex gives you AIDS, kids will think that kissing or feeling someone will give them AIDS," so it may be wise to spell out specifically how HIV is transmitted.

In some communities, specific discussions in the classroom may be frowned upon, however, and teachers may be encouraged to refer students to other sources such as an AIDS hotline or a local health services agency. In others, sexual transmission may be discussed specifically, but teachers cannot talk about preventive measures.

Surgeon General Koop has advised that information on HIV should be as frank and direct as possible. The Institute of Medicine/National Academy of Sciences publication *Confronting AIDS* says categorically: "Educators must be prepared to specify that intercourse — anal or vaginal — with an infected or possibly infected person and without the protection of a condom is very risky. They must be willing to use whatever vernacular is required for that message to be understood. Admonitions to avoid 'intimate bodily contact' and the 'exchange of bodily fluid' convey at best only a vague message."

Confronting AIDS: Update 1988 notes, "Efforts to stifle candid materials that discuss safer sexual practices and that are targeted at appropriate audiences may take a toll in human lives." The 1988 Gallup Poll revealed overwhelming public support for the public schools to teach what is called "safe sex" as a means of preventing HIV transmission (see box).

Unprepared or Unwilling Teachers

The best way to approach HIV education, according to health curriculum specialists and others, is to educate the entire school staff — with special emphasis on in-service sessions for teachers — before students receive classroom instruction. That way, teachers are more likely to have the information and the confidence to take on students' questions and will be more comfortable discussing HIV transmission and prevention after having had the opportunity to discuss such topics with health experts and their peers.

Even with preparation, some teachers may continue to be uncomfortable teaching about AIDS and HIV prevention or may be morally opposed to the curriculum. Some school systems rely on school nurses, teams of health teachers, or outside medical experts for HIV instruction if a classroom teacher does not feel comfortable or confident with the subject. The Presidential Commission on the HIV Epidemic recommends that "no member of the school staff should be forced to deliver education about HIV if he or she is not comfortable with the subject."

The K-12 Approach in Irvington, N.J.

HIV education in the ten schools in Irvington, N.J., is age-appropriate and is part of the district's K-12 family life education program. In grades K-6, the family life classes are taught twice a week by regular classroom teachers. In grades 7-12, health educators teach family life issues over an eight-week grading period.

In grades K-2, teachers talk to their students about the immune system and communicable diseases. Beginning in fourth grade, instruction includes information about sexual intercourse, STDs, homosexuality, and IV drug abuse. "We do it because there is a percentage of fourth graders who are interested," explains Claire Scholz, Irvington's psychologist for family life education. "Maybe 10 or 20 percent already are menstruating and are socially mature."

Most of the kids, Scholz adds, "don't get it the first time." The study of HIV prevention, she says, should be like the study of U.S. history: That subject is taught repeatedly through school, extending knowledge as students become more sophisticated in their understanding.

Parental Objections

State mandates for HIV education, as well as many school district policies, allow parents to exclude their

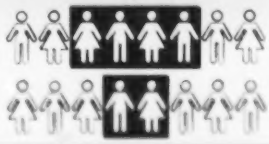
children from instruction if the content violates closely held religious or moral views. Although permitting students to opt out may be counterproductive to the goal of educating all youth, such a policy option could make HIV education more palatable to parents if it provides for educating parents first. Some otherwise objecting parents, when they understand the nature of the problem and of the school program to address it, may allow their children to attend classes. In the State of Washington, for example, parents cannot exempt their children from HIV education classes unless they attend a parents' meeting that familiarizes them with the instructional program.

Legal Challenges

School curriculum designed to educate children about HIV likely will withstand legal challenges by parents objecting to course content, according to William Fearen, former chairman of the NSBA Council of School Attorneys. If there are objections that the course content includes discussion of sex outside of monogamous marriage, says Fearen, the courts will view HIV as a public health concern and not support curriculum attacks on religious grounds. He says the HIV issue is similar to the courts' upholding, over parents' religious objections, school district policies that require, for public health reasons, immunization against communicable diseases.

An additional reason that HIV instruction probably will be protected by the courts, says Fearen, are that courts are reluctant to second-guess the local school board's curriculum choices so long as they fall within the general guidelines established by the state board of education. Parents first must exhaust established administrative procedures before seeking relief from the courts; courts uniformly have rejected parental complaints that sex education violates parents' rights to free exercise of religion or to privacy. To have the best chance of defending a mandatory curriculum addressing the sensitive subjects of sex, condoms, and other related matters, he says, school districts must make their programs legally defensible by involving parents and the community, by including abstinence as a form of HIV prevention, and by providing plenty of proof that the instruction is needed.

Another form of legal challenge may come from teachers who refuse to teach about HIV. According to Gwendolyn Gregory, NSBA's deputy general counsel, the teacher contract would not permit teachers to be excused from this responsibility on religious or moral grounds. Such refusal to teach would constitute a refusal to obey reasonable orders. As the Presidential Commission on the HIV Epidemic recognized, however, forcing a teacher to comply would not be educationally sound.



CHAPTER IV
A POLICY FRAMEWORK FOR HIV EDUCATION

Ultimately, the responsibility for HIV education rests with local school boards. As the elected or appointed officials of their local schools, board members are in the best position to ensure that an HIV education program reflects community needs and values and is designed and implemented appropriately and effectively.

In testimony before the Presidential Commission in March 1988, Jonathan T. Howe, then president of NSBA, said that although the how and when of HIV education were local decisions, teaching students about the threat of the disease was not an optional activity and that the health risk of HIV requires an aggressive educational campaign.

School board members can do much to assure the smooth creation and implementation of an HIV education program. Perhaps no element is more critical, however, than a school board's established policies and practices.

Policies Establish Goals and Guide Process

There are no foolproof ways for school boards — or, for that matter, any public officials — to avoid controversy, particularly regarding sensitive issues. But controversy, whether it surrounds HIV instruction, boundary changes, or increasing tax rates, can be managed and can be constructive if it is anticipated and planned for. A framework of board policies must be in place, however, before a school district can manage issues and make informed decisions that have broad-based support.

The critical elements of this policy framework related to HIV education include policies about:

- The school district's public information program;
- How the board involves the school community in decision making;
- The process for curriculum development, adoption, implementation, and evaluation; and
- How complaints about curriculum, instructional materials, and personnel are handled.

Also essential are policies supporting school board member development. Board members who are knowledgeable about their powers, their duties, and HIV will be better able to make informed and responsible decisions regarding HIV education. And not to be overlooked are those policies that support a sound policy development and adoption process.

Assuring Program Acceptance

The CDC's "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" notes that "the development of school district policies on AIDS education can be an important first step in developing an AIDS education program." In each community, the guidelines state, "the school board, parents, school administrators and faculty, school health services, local medical societies, the local health department, students, minority groups, religious organizations, and other relevant organizations can be involved in developing school policies" on HIV instruction.

The process of policy development can help resolve possible disagreements among various groups and individuals that have divergent ideas about what HIV education should and should not include. Policy establishes the board's commitment to implementing and maintaining an HIV education program, sanctions teachers to educate within limits, and provides guidance and instruction on the standards and goals for program activities and materials. The process can unite all segments of the school community, build consensus and support for HIV education, and promote close working relationships with community agencies and groups who also are involved in helping prevent the spread of HIV.

Many educators agree that HIV education is more easily accepted when the curriculum, materials, and activities are developed locally, with the community's needs and values in mind. The community will be more convinced of the need for HIV education and more likely to work toward establishing an effective program if educators use information from the local health department and other agencies to help target the program.

The CDC is helping all interested state education agencies and 16 interested local school districts assess HIV-related knowledge and behaviors among representative samples of secondary school students. Rates for teenage pregnancies and STDs can provide evidence of sexual activity and police blotters and counseling programs can indicate illicit drug usage. On the basis of local data and of discussions with parents and community members, educators can gear instruction to emphasize specific risks of sexual activity or of drug abuse.

Value of a Policy on HIV Education

Many school systems that teach about AIDS and HIV prevention do not have a specific policy in the board policy manual on how instruction will be delivered because such guidelines might be covered within existing policies on health education, sex education,

Assessing Community Needs, Environment, and Resources

A critical step in developing an HIV education program is assessing the community's needs and resources. The process below is based on materials in the *Administrator's Guide to Teaching About AIDS*, one of a series of publications on HIV education published by the National Safety Council.

1) **Attitudes and mores of the community.** Talk to drug counselors, parents, teachers, news media representatives, clergy, and others for a variety of perspectives on HIV and AIDS information needs.

2) **Community data.** Examine voter surveys and U.S. Census data for information on the community's socioeconomic status, values, and ethnic groups.

3) **HIV and related behavioral indicators.** How many cases of AIDS have been diagnosed? How many and what percentage of teenagers are estimated to use drugs or to be sexually active? What are the rates of pregnancy and STDs among teenagers?

4) **Community teaching resources.** Where might students go for information about HIV? Are there substance abuse programs or health services that need to know what the schools are teaching so information can be consistent, supportive, and complementary?

5) **Healthcare resources.** Are health professionals or other experts available to provide information on HIV prevention and AIDS and to help in designing the program?

6) **School resources.** Is a K-12 planned and sequential comprehensive program of school health education in place or planned? Who is qualified to teach about HIV? What level of skills do they have for teaching about health education or about sexuality and drug abuse? How much in-service will they require in those areas? How do teachers traditionally receive in-service education, and can those methods be used for an HIV program? Are human sexuality classes already provided? What funding is available for in-service and for purchasing materials? Will funding be available beyond the initial period of program implementation?

7) **Legal issues.** Do parents have the right to remove their children from classes they find objectionable? Does the state have guidelines or criteria for developing curriculum, selecting materials, or preparing teachers? Who is responsible for reviewing materials before they are purchased or used in the schools?

8) **Possible support, opposition.** What sources of both support and opposition to an HIV education program are present in the community? How can they assist in responding to concerns and building more support?

9) **Curricula available.** Review them, based on your assessment of the community.

teaching about sexually transmitted diseases, or on handling controversial subjects. In addition, the process of review, adoption, and evaluation of an HIV curriculum likely is covered by existing policies. These school systems should make sure that parents and teachers understand that HIV education will be planned and implemented according to these existing policies.

Some school officials, however, have chosen to spell out their position on HIV instruction in a specific policy. Creating a separate policy gives the board a sound understanding about HIV education and highlights the urgency for such programs. A specific board policy on HIV education can:

- Allay concerns that HIV education is happening in an ad hoc manner;
- Specify that the schools integrate HIV education into existing health, family life, and other subject areas and that appropriate information be given at every grade level each year;
- Provide guidance to school staff on content;
- Assure parents that they have the option to excuse their children from class if they do not wish them to participate.

In some cases, a policy adds needed credibility to the schools' efforts. "Without the strength of a policy statement, we wouldn't have strong support in the community" for HIV education, says Clarence G. Oliver, superintendent of the Broken Arrow (Okla.) Public Schools.

Whether a board decides to adopt a separate policy on HIV education or include it tacitly in existing policy, the driving force of policy is the board's public statement to the community: We care about our young people, and we want to protect their lives and health.

Assuring Program Effectiveness

School systems are under considerable pressure to introduce HIV education programs quickly because of the risk young people face in becoming infected with HIV. At the same time, curriculum and instruction must meet certain standards for students to be able to integrate and retain information about the disease.

The board can make sure, through its role in curriculum review, adoption, and evaluation, that HIV instruction is appropriate for grade levels, that students are getting the facts they need to protect themselves, and that sensitive issues are handled according to the board's and community's wishes. The board's leadership in the curriculum review, adoption, and evaluation phases of HIV education also creates opportunities for staff and community involvement, which are critical to program success.

How Boston's Program Got Started

The Boston Public Schools were among the first U.S. school systems to offer HIV education. When the school district was faced with two cases of AIDS in the fall of 1985, the schools had already prepared for such an event by developing an attendance policy for admitting students with HIV infection. That fall, school nurses instructed staff about how HIV is and is not transmitted. They also sent a pamphlet to all parents that explained AIDS and HIV in English and in nine other languages. The pamphlet included a letter from the citywide parents council, which had participated in developing the attendance policy in the spring of 1985. Because of this early involvement of parents and community members, says Michael I. Grady, M.D., medical director for the schools, there was no controversy about HIV education.

During the 1986-87 school year, the schools began offering an HIV education program for students in grades 8, 10, and 12 that included a 28-minute videotape produced by the schools and featuring a young person with AIDS. Students in grades 7-12 now receive two hours of HIV instruction from health teachers as part of a mandatory health curriculum that covers sex education and STDs. Plans to teach about HIV at the elementary level are underway.

From the start, the schools have worked closely with the City of Boston's Department of Health and Hospitals and the Massachusetts Department of Public Health; representatives from these agencies are members of the schools' advisory committee and consult on curriculum and staff in-service activities (for example, nurses from the city's hospitals conduct training sessions for teachers). The schools also work closely with the Massachusetts Department of Education, the city's Medical Foundation, a nonprofit organization in Boston, and other agencies serving youth.

One of the more innovative aspects of Boston's program is its use of peer instructors. During the 1988-89 school year, 30 middle school and high school students who were trained in a pilot project are participating as members of the district's HIV instructional teaching teams in each school. The students' leadership is critical to the program's effectiveness, says Grady. "Teens must have a say in developing and teaching about AIDS for instruction to be credible."

Staff Training

Many of the school systems with HIV education programs have found that training the entire school staff, not merely a representative group, was an important part of building support for HIV education before students received instruction. School staff members, as much as any other members of the community, may have misconceptions about AIDS and how HIV is transmitted. They can benefit from sessions that will help them protect themselves from infection.

In-service also can include discussion and exercises that address people's attitudes about AIDS and HIV to help them be more comfortable discussing the subject, a component that is particularly important for those who will be teaching students both formally and informally about HIV. The board member training program developed by NSBA includes exercises that a skilled facilitator can use with a variety of audiences.

School systems with HIV-infected students or staff members are apt to have training sessions for school staff to allay their fears and to teach them precautions for avoiding infection in school. The CDC recommends, however, that all schools offer such training because it is not always known when an HIV-infected person is present. The CDC's guidelines on "universal precautions" include wearing general-purpose rubber gloves (e.g., rubber gloves used for housework) to clean up blood and other body fluids and using a hospital-grade detergent (a made-fresh-daily solution of one part bleach to ten parts water is an inexpensive substitute) to clean all surfaces touched by blood or body fluids from any individual. These precautions help prevent transmission of other infections in addition to HIV.

CDC's Guidelines on Team Training

The CDC's education guidelines advise that a team of representatives, "including the local school board, parent-teacher associations, school administrators, school physicians, school nurses, teachers, educational support personnel, school counselors, and other relevant school personnel" should receive general training about:

- The nature of the HIV epidemic and means of controlling its spread;
- The role of the school in providing education to prevent transmission of HIV;
- Methods and materials to accomplish effective programs of school health education about HIV; and
- School policies for students and staff who may be infected.

In addition, say the guidelines, a team of school staff members responsible for teaching about HIV should receive more specific training.

A Sample Policy on HIV Education

The Broken Arrow (Okla.) Public Schools adopted this policy to guide its AIDS Prevention Education Instructional Program in November 1987. Many of the decisions represented in this policy reflect requirements of the state-mandated HIV education program in Oklahoma. The policy is presented here in annotated form to point out what one district's policy addresses, where local decisions have been made, and issues that have not been addressed. This policy is offered as an example for discussion purposes, not as a model.

The intent of the instructional program on Acquired Immunodeficiency Syndrome (AIDS) is to provide information about the disease, methods of transmission, and prevention appropriate to specified grade levels.

(This introductory paragraph might also include why the program is being provided – the program's objectives; it also should reflect that the subject matter will address HIV prevention rather than only AIDS, a clinical stage of HIV disease)

AIDS instruction will begin in Grade 5 and continue through Grade 12.

Who will be taught *(A clear statement that reflects a local decision to abide by the state's mandate for grade-level instruction, rather than to expand upon it)*

During the 1987-88 school year, instructional activities for Grades 5-12 will be conducted. Thereafter, appropriate curriculum will be taught in Grades 5, 6, 8, and 10.

When it will be taught *(The long-term plan provided does not recognize the benefits of integrating HIV education into a K-12 comprehensive health education program)*

Instruction for students in Grade 5 will be limited to the origin, history, and definition of AIDS. Excluded from instruction at this grade level will be methods of transmission and prevention.

What will be taught *(Following assessment of needs, other communities might decide to broaden the range of topics at this grade level)*

Instruction for students in Grades 6 and above will include the origin, history, and definition of AIDS, and the methods of transmission and prevention.

(This section reflects students' need for prevention information)

Specific instructional activities will be maintained in the instructional guide for AIDS education, to be monitored by the assistant superintendent for instructional services, who, through recommendation of revisions in the program to the Board of Education, will update and modify the curriculum as new information about AIDS is made public. Any curriculum and materials developed for use in the AIDS Prevention Education Instructional Program will be approved for medical accuracy by the State Department of Health.

How the program will be monitored *(This section emphasizes that changes to the program will occur when new medical information is available and that the board will approve program modifications; this section does not include reference to evaluating the achievement of program objectives or modifying the program to improve its effectiveness)*

During periods of AIDS instruction, students will be separated by sex and placed in the smallest groups possible, dependent upon student membership of the particular grade and school.

How it will be taught *(This section reflects local decision making on how HIV instruction can best be provided in keeping with this community's values)*

The building principal will assign the school nurse and/or other qualified personnel to teach AIDS prevention education.

Who will teach *(Guidelines regarding qualifications for teachers of HIV education should be provided to principals through administrative regulation or other means)*

Adequate training from health department personnel and/or private medical sources will be provided all nurses and teachers who are assigned to teach AIDS prevention education.

How teachers will be trained *(By requiring that in-service be provided by trained medical professionals, assurance is given that medical information will be accurate; the need for health educators who know how to address information, attitudes, skills, and practices is not acknowledged)*

Prior to the start of the student instructional program, and at any time thereafter, parents and guardians of students who will be involved with the curriculum and materials will have an opportunity to preview the curriculum and materials in a specific program being presented. Thereafter, any parent or guardian may review the curriculum and materials at any time including any revisions in the program to update and modify the curriculum as new information about AIDS is made public.

Parental involvement/ review *(This section assures that parents have the right to review curriculum materials)*

The school district, at least one month prior to teaching AIDS prevention education in any classroom, will conduct for the parents and guardians of the students involved, during weekend and evening hours, at least one presentation concerning the curriculum and materials that will be used for such education. Parents and guardians will be given the opportunity to have their student(s) exempt from participation in the AIDS instruction program.

Parental option *(This section makes clear that the school district is being open with parents by calling for presentations to be made during times when parents can attend; the statement also indicates that it is parents who must take the initiative to remove their child from the program)*

On an annual basis, all employees of the school district will view an appropriate training film which addresses all learner outcomes of the AIDS prevention education program. A school nurse will present the film and be available for questions following viewing of the film.

HIV Education for all employees *(This section recognizes that all employees should be educated about HIV and AIDS, but a statement of objectives is missing)*

One District's Approach to Staff In-Service

The entire staff of the Adams County (Colo.) District 12 schools, including school custodians, bus drivers, and food service staff, received training in HIV prevention in September 1987. The sessions, conducted by school district nurses trained by the Colorado Department of Health, covered what AIDS is, how HIV is and is not transmitted, the risks to adolescents and adults, and the use of universal precautions. New employees who join the district during the year are given similar training.

Curriculum and instruction staff, who themselves were trained by University of Colorado instructors, provide an additional three hours of in-service training to high school teachers (instruction at the middle and elementary school levels begins in the 1988-89 school year). In-service includes an overview of information provided by a nurse-epidemiologist, the viewing of a videotape, and small-group discussions. Assisting at in-service sessions are specially trained HIV instruction cadres (one for each school) whose members also are available to team teach with classroom teachers or to take over HIV instruction if a classroom teacher is uncomfortable with the subject. The cadres are composed of teachers, administrators, and health and medical professionals from the community.

Educating the Public

Many school systems credit well-planned public information programs on HIV with helping usher in education programs without incidence. School officials may approach their communities in different ways; there is no one sure-fire way to garner support.

Some districts hold open forums for citizens to ask questions and air their concerns about AIDS and HIV education; some districts survey citizens on specific issues related to curriculum and instruction; and other districts send parents and other community members information about HIV and what the school program will entail. Some schools use a variety of ideas to reach the public, including the following:

- The San Francisco Unified School District sends parents a letter that invites them to attend an HIV education community information meeting, briefly outlines HIV education for middle and high school students, and explains how parents may exclude their children from participating. These meetings, which are held on four evenings in different areas of the city, are cosponsored by the school system and the San Francisco Department of Public Health. Parents also receive a pamphlet — produced jointly by the district, the health department, and Kaiser Permanente Medical Care Program — that explains HIV transmission, prevention, and sources of further information.
- The Fairfax County (Va.) Public Schools send parents of fifth and sixth graders a "Familygram" including a letter from the superintendent about how HIV education fits into the existing human growth and development curriculum and a series of questions and answers about HIV and how it is spread. Emphasis is given to the role of parents in talking with their children about HIV and related issues.
- Before introducing the district's HIV education plan in the Pasadena (Texas) Public Schools, Superintendent E.T. Lon Luty worked with grass-roots school and community organizations. He met with PTA leaders, his "key communicator" group, local religious leaders, and a superintendent-citizens advisory group, which included such local opinion leaders as newspaper editors, bank presidents, and the head of the chamber of commerce. He explained the need for HIV education and asked for these citizens' help in introducing a school program; he got the "go-ahead" from all of them. School officials made instructional materials and videotapes available for the community to preview.
- The Broken Arrow (Okla.) schools held an open HIV education session for the public in which school officials discussed the proposed curriculum and previewed videotapes that would be used with students. The session also featured a question-and-answer period in which five panelists — a school attorney, a health official, a local physician, a health instruction specialist, and the superintendent — responded to citizens' questions and concerns. Following the meeting, panelists responded to written queries that were submitted at the public meeting and to others that resulted from media coverage of the session. School administrators, sometimes accompanied by a physician or another member of the panel, continued the educational process by making presentations at meetings of various community and parent groups.

Educating the public also means working with the news media. Local reporters, of course, should be briefed about impending HIV education plans so that the whole story can be told accurately. They also should be invited to attend public forums and other community or school-parent meetings.

Some school systems have found that setting up a special committee or task force to handle media inquiries is particularly helpful. For example, after it was publicized that an HIV-infected child was attending one of the Adams County (Colo.) District 12 schools, central office administrators who composed the district's AIDS Task Force met almost daily to make plans for handling the press. Although introducing HIV education might not require crisis measures, it does require a media plan.

School-Community Advisory Committees

Perhaps the most critical element in introducing HIV education is inviting the community to participate in the development of a school HIV education program. Staff and community participation does several things:

- It lets parents and citizens know the program will not attempt to teach anything that would not be in keeping with the community's values.
- It makes parents and other community members part of the process, so they will have a sense of contribution and pride in the program.

Public Relations Skills for Board Members

Introducing HIV education requires the same public relations skills that the board would need for any potentially difficult situation. Some of the basics involve:

- Developing short and long-range plans for HIV instruction and for dealing with potential controversies;
- Appointing one spokesperson—a board member, the superintendent, the school public information officer—to handle all press and public inquiries, and making sure that person is well-briefed and well-suited to respond;
- Letting staff, parents, and other community members know that curriculum and instructional materials are available for their review; and
- Having an open attitude—never say, "No comment."

Beyond the basics, keep in mind that some people will find HIV infection an embarrassing and uncomfortable subject, so it's best to give fellow board members, administrators, teachers, and community members an adjustment period before you expect them to be able to discuss HIV instruction frankly and openly.

Discomfort with the subject of HIV instruction can be used positively to emphasize the importance of training for teachers. Note that people—teachers, health providers, board members—may bring personal attitudes, biases, and misinformation to the discussion of HIV education if they have not had the opportunity to explore and address their attitudes and beliefs.

- It ensures accountability, so that students will receive the information they need to protect themselves in the way the community believes is best.

Although the size and composition of HIV education advisory committees vary, they often include parents, students, local religious leaders, physicians, civic leaders, representatives of youth organizations and local health and social service agencies, as well as teachers, administrators, and other school employees. The CDC's guidelines suggest that school officials should seek to involve people who represent the school-community population.

The steering committee for the Denver Public Schools, for instance, includes representatives of black, Hispanic, Asian, and Native American groups. Board members or administrators can establish an advisory committee through an open invitation to the community or by inviting or appointing individuals who have credibility in the community and perhaps have made known their positions on HIV education.

Collaboration with Health Authorities and Others

Most educators agree that the actual writing of curriculum should be left to health curriculum specialists. But because information about HIV is updated continuously, and because some aspects of the virus and its transmission require sophisticated medical knowledge, it is essential that school officials work with the medical community in developing curriculum, creating in-service programs for staff, and assembling HIV resource teams to help school staff.

Assistance is available from local or state public health officials. All state health departments have a designated AIDS/HIV coordinator and have established networks of experts who can be helpful to local jurisdictions. Seek additional assistance, if needed, from the local chapter of a professional society, such as the American Medical Association, or from HIV specialists or researchers at university medical centers. Often, health agencies or medical centers (including some hospitals) can send health professionals to the schools to offer expert advice on course content or to serve as speakers to supplement HIV education programs.

Advisory Committees In Action

Some school systems establish a special HIV education advisory committee to develop a community consensus on HIV instruction. The 16 school districts within Trumbull County, Ohio, formed a countywide task force on HIV education in 1988. In addition to school administrators, teachers, and representatives of school employee unions, the 84-member task force included parents, the county prosecutor, physicians (including an HIV specialist), state and local health department officials, and representatives of the Red Cross, Planned Parenthood, and other community agencies. The task force divided into three subcommittees to develop a policy, review educational materials, and determine in-service needs for school employees and the communities.

After specialists from the school districts designed an HIV education curriculum, a clergy review committee representing seven religious denominations in the county reviewed the materials. The clergy were asked to advise because "there were a lot of emotions in the communities" that related to personal views about religion, sexuality, and homosexuality, says Elizabeth Graben, assistant county superintendent. The result: "The clergy review committee approved the curriculum and suggested areas where we could stress abstinence and where parents could become involved." The involvement of two advisory committees for HIV education helped provide consensus and stability to the districts' efforts, says Graben.

In other districts, school officials have called on the services of an ongoing advisory committee. In Irvington, N.J., for example, a long-standing advisory committee discusses all issues related to the district's comprehensive K-12 family life and sex education program. The advisory committee, which includes parents, clergy, physicians, and teachers, was formed in 1980 in response to a state mandate. The committee is open to anyone who wants to participate; it usually has approximately 25 members.

The Irvington schools introduced HIV education in 1985 without controversy, in large part because of the involvement of the advisory group, says Claire Scholz, psychologist for family life education. "If a particular group tried to raise objections," she says, "we let them know the vast majority of parents are behind us."

Project PEAK

During the 1987-88 school year, some 7,000 secondary school students learned about HIV prevention through Project PEAK (for Prevention, Education, Attitudes, and Knowledge), which links the Akron, Barberton, and Summit County public schools, as well as area Catholic schools, with the Akron, Ohio, public health service. The agency developed a countywide HIV curriculum guide for students in grades 7-12 and serves as an HIV and STD resource clearinghouse, providing schools a slide presentation on STDs, school policies on HIV, audiovisual materials, and CDC information. Since 1984, the agency also has presented HIV instruction to students, including handicapped students and students in alternative schools, and has provided in-service training for teachers.

Through public health clinics and outreach programs, the agency gets the HIV prevention message across to runaway youths and prostitutes. The agency keeps teachers and administrators abreast of HIV epidemiology and research through a bimonthly newsletter. The program tries to get across to school staffs the following point about HIV education, says Project PEAK Director Shirley A. Anguilo: "It is important to have people who know what they're talking about. We tell them, 'If you don't feel comfortable with the subject, that's okay. Other people can teach it'."

The CDC's guidelines say the schools have a responsibility to help ensure that the HIV prevention message reaches all school-age youth, including special education students, and even those who do not attend school (dropouts and runaways, for example). School officials should work with organizations that serve youth in the community — the United Way, Red Cross, YMCA, churches, athletic leagues, social organizations — with whom they can coordinate HIV education efforts. The Los Angeles Unified School District, for example, provides training and follow-up services to staff members from 20 local agencies serving youth who do not attend school.

Local organizations also can contribute to in-school HIV education efforts. In Seattle, a coalition of community organizations educates high school newspaper editors about HIV so they can educate fellow students and school staff through articles in student publications.

Ensuring Consistency

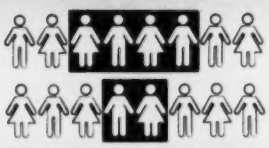
HIV education generally should embody several consistent messages:

- AIDS is a medical problem that results from HIV infection.
- Certain behaviors increase the risk of HIV infection.
- The risk of becoming infected with HIV can be virtually eliminated if people avoid engaging in high-risk behaviors.
- HIV is not easily transmitted.
- People infected with HIV are not to be shunned or otherwise made to suffer further for their illnesses.

School boards should make sure that what teachers tell students about HIV, what curriculum materials say about HIV, and how board policies address students or school employees with HIV embody these messages.

Planned Parenthood Programs

The Planned Parenthood Federation of America sponsors a variety of programs at the local level that help schools teach about HIV prevention. In Cambridge, Mass., for example, the organization sponsors the YET (for Youth Expression Theater) Troupe. Student actors aged 13 to 17 from the greater Boston area put on about 30 performances a year, many of them in public middle schools. The performances feature a series of semi-improvisational skits on subjects such as sex, STDs, teen pregnancy, drugs, and HIV. After the performances, trained counselors who accompany the troupe lead classroom discussions with students. In addition to being entertaining, the performances about sexuality issues such as HIV prevention are valuable because "they get the kids to buzz and talk about it," says YET's director, Jessica Goldhirsch.



CHAPTER V
CURRICULUM AND INSTRUCTION

The principal purpose of education about HIV is to prevent new HIV infection. In the public schools, HIV education should ensure that students learn the information and skills they will need for adopting and maintaining the types of behavior that virtually eliminate the risk of infection. Training and instruction, moreover, should address the broad range of behaviors among young people and aim at helping them choose and maintain healthy behaviors. In the course of planning for and presenting HIV instruction, of course, schools should direct similar efforts through their education programs to promote healthy behaviors among school employees and the public.

Goals of HIV Education

There is general agreement that the primary goal of HIV education in schools is to protect young people from infection with the virus. School leaders, educators, health officials, parents, and community members may not always agree on other goals.

To move forward with HIV education, school officials and parents must determine the following:

- Will the program be limited to teaching students about abstinence from sexual intercourse and drugs?,
- or, Will the program acknowledge that many students may engage in high-risk behaviors and teach them what they need to know to protect themselves, including abstinence from sexual intercourse, using condoms and spermicides, and never sharing IV paraphernalia?

The CDC's guidelines suggest an approach that addresses the wide range of behaviors practiced by students (see box).

The U.S. Department of Education's *AIDS and the Education of Our Children* also supports this position. The guide for parents and teachers outlines four principles of HIV education:

1) Help children develop clear standards of right and wrong ("teach restraint as a virtue" and "present sex education within a moral context").
2) Set a good example.
3) Help children resist social pressures to engage in dangerous activities.
4) Instruct children about HIV ("teach about sex in a way that emphasizes the reasons for abstinence," and teach about use of condoms "in an appropriate moral context").

Many school leaders and parents might find that an emphasis on the "Just Say No" approach, as some educators and HIV specialists have dubbed the department's advice, is unrealistic. Others, however, might find that the guide's more conservative message and emphasis on strengthening children's values is appropriate for them.

Responses from a survey of superintendents published in the January 1988 issue of *Phi Delta Kappan* suggest that top educators do not believe that the "Just Say No" approach is adequate: Although 60 percent of superintendents who responded agreed that HIV programs "should specifically address the moral

CDC's Goals for HIV Education

The CDC's "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" says HIV education programs in the schools should "enable and encourage young people who have not engaged in sexual intercourse and who have not used illicit drugs to continue to:

- Abstain from sexual intercourse until they are ready to establish a mutually monogamous relationship within the context of marriage; and
- Refrain from using or injecting illicit drugs.

For young people who have engaged in sexual intercourse or who have injected illicit drugs, school programs should enable and encourage them to:

- Stop engaging in sexual intercourse until they are ready to establish a mutally monogamous relationship within the context of marriage; and
- Stop using or injecting illicit drugs.

Despite all efforts, some young people may remain unwilling to adopt behavior that would virtually eliminate their risk of becoming infected. Therefore, school systems, in consultation with parents and health officials, should provide AIDS education programs that address preventive types of behavior that should be practiced by persons with an increased risk of acquiring HIV infection. These include:

- Avoiding sexual intercourse with anyone who is known to be infected, who is at risk of being infected, or whose HIV infection status is not known;
- Using a latex condom with spermicide if they engage in sexual intercourse;
- Seeking treatment if addicted to illicit drugs;
- Not sharing needles or other injection equipment; and
- Seeking HIV counseling and testing if HIV infection is suspected."

and values issues associated with AIDS," 76 percent also agreed that their schools "should teach about AIDS as a health issue, not as a moral issue." Some established curricula, such as the curriculum guide developed by New York state, balance the moral and health messages by stressing abstinence from drugs and sex while providing information on risk-reducing practices.

Practical Program Considerations

In addition to the CDC's recommendations, each school system might have goals and objectives it wishes to address in HIV education and must determine strategies for accomplishing them. Some questions to help school leaders focus on what they would like to accomplish, and how, include:

- Which teachers in our system should be delivering HIV education, and how do we identify them?
- Specifically, what training do our teachers need?
- Who will provide training to teachers? Should they be trained before curriculum decisions are made to improve teachers' ability to set objectives and select and evaluate materials; or should they be trained after materials are selected on how to teach particular programs? Or should they be provided with general HIV education and program-specific training after programs are selected?
- What programs are in place already that will support HIV education? Exactly where will we fit HIV education into the curriculum at each grade level? If our schools are not providing more comprehensive health education programs, how can we begin to implement such programs?
- How much classroom time can and should we allot to HIV education at each grade level? What other formats should we use (for example, assemblies, bulletin boards, special health clinics)?
- In what ways can we use local resources in our educational programs?
- What funds are available to finance HIV education? Are they sufficient to cover materials and training, as well as adult education efforts? Do we need to put together a funding proposal once we have figured out all the details of what we would like to do and what it will cost?
- What state and local technical support and resources are available within both the education and the health communities?
- What is the gap between what schools can offer and what people engaged in high-risk behavior need, and what can we do to bridge that gap? Once we understand the constraints of our delivery system, what alternatives are available to get information and services that schools can't provide to students and staff who may need them? Such services might include counseling, drug treatment programs, medical care, birth control information, testing for HIV antibodies, and intervention in known or suspected cases of child abuse.
- What should be done about educating special populations, including non-English-speaking and handicapped students? What assistance is available to develop programs for special populations?
- What can we do to help community organizations provide HIV education and services for out-of-school youth?

Educating Hispanic Youth

HIV education for students and parents in the 15 school districts in Hidalgo County, Texas, is conducted mostly in Spanish. Located in the Rio Grande Valley, the county has many immigrants and a large number of migrant workers. Although no comprehensive HIV curriculum exists in Spanish, educators translate the information from their English curricula and materials into Spanish for classroom use. Educators recognize that translations must be done by those who not only know the language, but also know the appropriate colloquial phrases and understand the cultural context.

Through a state-funded program, the county's Planned Parenthood staff trains teachers about HIV and provides classroom instruction to students and their parents. In a couple of districts, HIV education and other family life issues are discussed at father-son and mother-daughter workshops for students aged 9 to 11 and their parents.

"In teaching, we consider the values of the family and individualize training as much as possible," says Isaac Trevino, Jr., minority AIDS education project specialist for Planned Parenthood. Because of the emphasis on religious and cultural values within Hispanic families, it's important to educate parents so they can have open communication about HIV prevention with their children at home, he says. "Get parents' approval and suggestions, and let them air their feelings." He says the schools' HIV education program has had "almost 100 percent acceptance" by parents.

HIV instruction should be arranged so that migrant children, who often attend special pull-out language or compensatory classes, can attend, says Trevino. And the HIV prevention message should address the fact that Hispanic men and women are at risk of infection with HIV, and that "despite the macho image, plenty of Hispanic men are bisexual or homosexual," he says.

In talking to juvenile delinquents about HIV, Trevino uses an even stronger message. "They're more streetwise. I use 'shock therapy' and tell them they could die from AIDS in a few years."

HIV Education for Handicapped Students

In providing HIV education for handicapped students, educators first should make sure all special students are reached, including those attending classes off the school grounds, says Fred Weintraub, assistant executive director of the Council for Exceptional Children (CEC). Next, says Weintraub, make sure instruction meets individual needs. The ability to grasp some aspects of HIV instruction may vary tremendously, he says.

Some special students need the same-age education as other students. But some special students will not be able to understand the concept of transmission, for example, and will require adjustments in the content of the curriculum. "You may have to decide what information is really important," says Weintraub. Other students, particularly those who are deaf or blind, may need a different mode of presentation.

Says Perry Samowitz, training director for the Young Adult Institute (YAI) in New York City, "There is no school curriculum available geared to people with disabilities." Adding to the difficulty, he says, is that school administrators and parents resist acknowledging that these young people are sexually active and need instruction.

The Association for the Advancement of Health Education has identified HIV instruction for handicapped children and youth as an objective of its CDC-supported project. It will be working with such organizations as CEC and YAI to assess needs and identify the most appropriate approaches to HIV education for each disability group.

CDC's Guidelines for Grade-Level Instruction

The CDC's guidelines recommend that in early elementary school, education "principally should be designed to allay excessive fears of the epidemic and of becoming infected." Teachers should emphasize, for example, that AIDS is very hard to get, and that it does not usually affect children.

At the late elementary and middle school levels, say the guidelines, HIV education should convey more specific information, such as the following:

- AIDS is caused by a virus that weakens the ability of infected individuals to fight off disease.
- The AIDS virus cannot be caught by touching someone who is infected, by being in the same room with an infected person, or by donating blood.
- It can take several years after becoming infected with the AIDS virus before symptoms of the disease appear. Thus, people who are infected with the virus can infect other people – even though the people who transmit the infection do not feel or look sick.
- The AIDS virus can be transmitted by sexual contact with an infected person; by using needles and other injection equipment that an infected person has used; and from an infected mother to her infant before or during birth.

Junior high and high school programs should include information such as the following:

- The risk of becoming infected with HIV can be virtually eliminated by not engaging in sexual activities and by not using illegal intravenous drugs.
- HIV may be transmitted in any of the following ways: a) by sexual contact with an infected person (penis/vagina, penis/rectum, mouth/vagina, mouth/penis, mouth/rectum); b) by using needles or other injection equipment that an infected person has used; c) from an infected mother to her infant before or during birth.
- Although no transmission from deep, open-mouth (i.e., "French") kissing has been documented, such kissing theoretically could transmit HIV from an infected to an uninfected person through direct exposure of mucous membranes to infected blood or saliva.
- Persons who continue to engage in sexual intercourse with persons who are at risk or whose infection status is unknown should use a latex condom (not a natural membrane) to reduce the likelihood of becoming infected. The latex condom must be applied properly and used from start to finish for every sexual act. Although a latex condom does not provide 100 percent protection – because it is possible for the condom to leak, break, or slip off – it provides the best protection for people who do not maintain a mutually monogamous relationship with an uninfected partner. Additional protection may be obtained by using spermicides that seem active against HIV and other sexually transmitted organisms in conjunction with condoms.
- Behavior that prevents exposure to HIV also may prevent unintended pregnancies and exposure to the organisms that cause chlamydia, gonorrhea, herpes, human papillomavirus, and syphilis.

Course Content

Information about the biology of HIV, the signs and symptoms of HIV infection and AIDS, and the social and economic costs of the epidemic might be of interest to students, say the CDC's guidelines, but it is not essential. What is essential is specific information that can help young people avoid infection, including the emotional and social factors that influence types of behavior associated with HIV transmission.

In addition to the CDC's guidelines, educators can use a variety of resources to make sure HIV instruction is appropriate for students' social, emotional, and intellectual development. For instance, the Boston-based National Coalition of Advocates for Students publishes, as part of a packet of information on criteria for evaluating an AIDS curriculum, a guide on how to match HIV education to childhood development. Also, some published curricula explain how to integrate HIV information into health classes at various grade levels.

Growing Healthy, a curriculum used nationally that has been revised under a CDC grant to include HIV information for grades K-7, explains appropriate instructional objectives and course content for students at different grade levels. At grades 4-6, for instance, *Growing Healthy* covers a general introduction to the immune system, concrete information about viral infection and the transmission of HIV, information on prevention as well as on allaying fears by reinforcing how people do not get infected with HIV, information on helping students to learn and express compassion for sick people, and the general message that people with HIV disease need friends and support.

Teaching AIDS, a popular resource guide for grades 7-12 published by Network Publications/ETR Associates, includes a suggested curriculum, teaching plans, and materials for classroom activities. ETR recently published a curriculum for grades 5-8 called *Into Adolescence: Learning About AIDS* and a new guidebook for educators and parents on talking about HIV to children aged ten and younger called *Does AIDS Hurt?: Educating Young Children About AIDS.* In instruction programs for children younger than ten, "teachers should be prepared to talk about AIDS and answer children's questions," says Marcia Quackenbush, coauthor of *Teaching AIDS* and *Does AIDS Hurt?*

Students Need to Learn Skills

Whether an HIV education program is offered on its own or as part of a comprehensive family life/health education program, HIV instruction should focus on developing the skills kids need to avoid unhealthy behaviors. Those skills that are crucial if significant behavior changes are to be made include:

- Decision making
- Assertiveness
- Resisting peer pressure
- Negotiating, and
- Building self-esteem.

Instruction also should include where students can get more information and help. If instruction does not cover information such as how to obtain and use condoms and where to go for HIV antibody testing and counseling, teachers should tell students where they can find answers and assistance.

Selecting and Evaluating Curriculum

Growing Healthy, as well as the Education Development Center's *Teenage Health Teaching Modules* (THTM) and *Preventing AIDS*, a stand-alone HIV education unit developed for incorporation into THTM for middle level and senior high school students, are examples of ready-made curricula that schools can use to teach about HIV. Many states and school systems — Michigan, New York, Dade County (Fla.), and Eugene (Ore.), to name a few — have developed their own curricula, drawing upon the strengths of curriculum specialists, HIV experts, education officials, and, in many cases, upon the participation of parents and other community members in defining what HIV instruction should include.

With so many curriculum resources available, say many health education specialists, local school officials to some extent would be "reinventing the wheel" to create their own curriculum materials. In some communities, however, developing a curriculum is an important part of the process by which school staff members and the community can learn about HIV themselves and establish an understanding of the need for HIV education.

Before deciding whether to develop a curriculum, select a commercially published one, or adapt one that was created by a state education department or another school system, educators would be wise to review the curriculum resources already available. Up-to-date information on materials is available from the CDC's Combined Health Information Database (CHID). The American Foundation for AIDS Research (AmFAR) has published a directory of resources that includes an evaluation criteria guide for videotapes, print materials, and curriculum/instructional programs (the directory is listed in the resource section of this report).

Once available curriculum materials are identified, educators should review materials carefully to determine whether they meet with program objectives and are in keeping with community values. The following standards, recommended by NSBA to the Presidential Commission on the HIV Epidemic, can guide curriculum evaluation:

- Does the curriculum give simple, clear, and direct information?
- Is the curriculum factually accurate — is it based on the latest available information and subject to regular updating as new information becomes available?
- Is the curriculum a sequential program tailored to students' level of development, both emotionally and intellectually?
- Does the curriculum focus on teaching healthy behavior, with the scientific terminology and medical aspects of the disease kept in proper perspective?

- Does the curriculum stress positive personal values and give the clear message, in a way that is acceptable to the community, that multiple sexual partners and intravenous drug use increase the risk of HIV infection? Are students encouraged to develop strategies for resisting peer pressure to engage in activities that do not conform to their personal values?
- If discussion of the risks of HIV infection is included, is the emphasis on high-risk behaviors and is the message given that anyone who engages in such behaviors is at risk, regardless of race, sex, age, or sexual orientation?
- Is discussion of student concerns and fears specifically included in the curriculum? Has consideration been given to the possibility that some students may already have experienced the loss of a friend or relative who had AIDS?
- Does the high school portion of the curriculum address sexuality, including homosexuality, in a responsible way that is consistent with community values?
- While continuing to encourage students to choose abstinence, is there a way to point out to older students that for individuals who are sexually active, condoms greatly reduce the risk of HIV infection, and that certain sexual practices increase the risk?
- Does the program address social issues such as unreasonable fear of people with AIDS? Does it help students appreciate the economic and social costs to the country of HIV disease without causing them to lose a sense of compassion and understanding for those who are infected?

The National Coalition of Advocates for Students (NCAS) has issued a checklist of criteria for evaluating an HIV curriculum. Some of the questions are included in the preceding list; others are:

- Does the curriculum focus on teaching healthy behaviors and not just on the medical aspects of the disease?
- Are several class periods provided to give each student multiple opportunities to learn decision-making skills and how to apply them to HIV issues?
- Does the program provide adequate training for those teaching the curriculum?
- Is the same information given in their own language to those students who have a limited proficiency in English?
- Is the information provided appropriately to students who have hearing and visual impairments and to students who are severely disabled?
- Has sufficient community and parental support been generated to give teachers the backing they need to teach sensitive material in a direct manner?
- Does the curriculum facilitate an ongoing dialogue with parents on these issues?

Selecting and Training Teachers

In the elementary grades, where students generally have one teacher, HIV education should be provided by the regular classroom teacher, say the CDC's guidelines, because that person likely is trained and experienced in child development, age-appropriate teaching methods, child health, and elementary health education methods and materials. In addition, classroom teachers are the most appropriate teachers for elementary school students because these teachers know and are more sensitive to individual students and to their aptitudes and levels of development.

At the secondary level, say the guidelines, health teachers preferably should provide education about HIV because they have the training and experience in adolescent health and development, age-appropriate teaching methods, and health education methods and materials for secondary schools (such as those for teaching about human sexuality, communicable diseases, and drug abuse). In secondary schools that do not have a qualified health education teacher, "faculty with similar training and good rapport with students should be trained specifically to provide effective AIDS education," say the guidelines.

Some school systems use health education or family life specialists to teach HIV education in all grades; other systems use physical education teachers, biology or general science teachers, or home economics teachers to teach about HIV, especially at the middle level and in high school. In other districts, students are taught by health professionals, including school nurses, local physicians, or staff members from a community health agency or nonprofit organization such as the Red Cross or Planned Parenthood.

Students themselves play a significant role as peer teachers in HIV education programs in some school districts. The Boston schools, in a pilot program planned to begin in September 1988, will use peer teachers. At a middle school and high school in each of the city's five districts, students trained by the city's Medical Foundation will join health teachers as members of HIV instructional teams.

Staff training is similarly varied. Many districts call on the services of their local, county, or state health departments, the medical staff of a local hospital, or a health education consultant experienced in

The CDC's Database of Resources

The Combined Health Information Database (CHID) is a computerized bibliographic database of health information and resources, developed and managed by the PHS, to which the CDC has added an AIDS School Health Education subfile. The subfile contains abstracts of programs, curricula, guidelines, policies, regulations, and materials.

To search CHID for AIDS School Health Education information, request a password from BRS Information Technologies (1200 Route 7, Latham, N.Y. 12110; 800/345-4277). There is an annual fee of $75 for the password; the cost per hour for searches depends on the BRS search service used. To submit HIV education information, such as a locally developed HIV curriculum, for inclusion in CHID, write to the CDC, Division of Adolescent and School Health, 1600 Clifton Road, NE, Atlanta, Ga. 30333.

People Who Have AIDS as Guest Speakers

Some school districts have invited people with AIDS (also known as PWAs) into the classroom to provide students valuable lessons and insights about HIV prevention. The San Francisco schools reportedly were the first to have PWAs lead HIV discussions in tenth grade classrooms at the request of family life teachers. The volunteers receive two days of training from the city health department. As of July 1988, eight high schools had used PWAs, and "reception has been uniformly positive," reports Joan Haskin, director of health services for the schools.

In Los Angeles, several high schools have had PWAs address classes through a program called Milagros (miracles) run by El Centro, a community mental health center. "The kids really enjoy the sessions, especially if it is with someone who is ready to take on personal questions," says David Marquez, a social worker with El Centro. "The message finally strikes home, and the illness is brought alive. Kids see the reality of the illness."

PWAs also are effectively used for teacher in-service training and for staff and community education. Coming face-to-face with a person who has AIDS and hearing first-hand about HIV and its implications for people can have a dramatic effect on people's attitudes about HIV.

HIV instruction. Some training sessions last an hour or two; others, like that of the Broken Arrow (Okla.) schools, provide two days of teacher training in HIV education each year.

On the national level, ETR Associates of Santa Cruz, Calif., under a CDC grant, is developing four teacher training models for HIV education. ETR's Teaching AIDS Training Project is based on the firm's successful Family Life Education Trainings dissemination model, which has been used in more than half of California's secondary schools. The CDC's funding of state and local education agencies, which has been expanded to 54 states and territories and 16 cities in 1988-89, supports a variety of strategies for teacher training and staff in-service.

No matter who is trained to teach students formally about HIV, the role of other school employees and parents in reinforcing and supplementing HIV education should be recognized. Not all learning goes on in classrooms. Staff, including administrators, guidance counselors, team coaches, and school secretaries, bus drivers, and custodians, should be able to correct misinformation and, as appropriate, help students deal with their concerns about HIV.

Keeping the Curriculum Up-to-Date

A constant challenge in HIV education and prevention efforts is keeping abreast of research and developments about HIV infection. Newspapers and television reports will keep you current on general HIV issues, but education programs need more specific resources. Some HIV specialists read the regular HIV/AIDS reports published by the CDC and state health departments. Others subscribe to newsletters or computer information services, such as the National School Public Relations Association's EDLINE.

Media attention to new research may cause instructional staff to question the credibility of what they are teaching. It is important to establish a process by which information can be verified, ideally with public health officials at the local, state, or federal level. News stories about research can provide opportunities for teaching students about the scientific research process, including the process of evaluating new information. Teachers can explain, for instance, how and why peer review is used by scientists and how conclusions are reached over time and not on the basis of one study.

Evaluating the Program

A critical aspect of an HIV prevention program is evidence through evaluations that instruction is effective. Such information provides the basis for making decisions about changes that could improve the program. Some school districts use informal feedback from students, parents, teachers, administrators, and community members. Other districts test students' knowledge and attitudes both before instruction commences and after it is completed.

In its *Administrator's Guide to AIDS Education*, the National Safety Council suggests evaluation should include:

- Formative evaluation, which takes place during implementation and involves using feedback to correct problems as they arise in the program;

Medical Students as Teachers

Medical and health experts from outside the school system can provide expertise and a different perspective for staff training, curriculum design and content, and special HIV programs for students. Volunteers from the American Medical Student Association, for example, will visit schools to train teachers or provide classroom instruction. The advantages of using medical students for instruction are that they usually have access to the latest HIV information and teaching techniques, they are accustomed to talking frankly about health issues, and they generally are close in age to the students.

The STATS project (for *Students Teaching AIDS To Students*), as of July 1988, had trained medical students at 67 medical schools — more than half the nation's total. In one of five pilot projects, STATS volunteers are working with schools, churches, and juvenile detention centers in the Columbia, Mo., area; other pilot projects are in New York City, Chicago, Chapel Hill, N.C., and Lubbock, Texas.

STATS has developed an instructional manual that includes a curriculum for grades 7-12 and classroom activities. "Everything in the curriculum is negotiable," notes Grant Haven, a STATS cofounder. "We work out with the school board what the presentations will include, and that varies significantly from New York City to Lubbock, Texas."

- Summative evaluation, at the end of the program, to assess the program's effectiveness through data obtained through such methods as interviews, questionnaires, and observation;
- Examination of health records and other data from the school nurse's office and from other community healthcare providers to compare the number and type of inquiries before and after the program and to compare the incidences of teen pregnancies, STDs, and drug use;
- Comparison and analysis of data from formative and summative evaluations to see whether the program reached its goals and to analyze how the program might be improved.

Plans for how the evaluation will be conducted should be designed while the program is being developed. Evaluation should be based on a program's goals. If the goals are not being achieved effectively, the evaluation plan should include strategies for revising the program.

What About Conflicting Information?

How do you know whether information on HIV is authoritative and reliable? This is a common and important question, especially in the wake of controversy over two recent publications that offered views on the risks of HIV infection that were significantly different from those of the CDC: an article published in *Cosmopolitan* magazine downplayed the risk of heterosexual HIV transmission; and a book by sex therapists Dr. William H. Masters, Virginia E. Johnson, and Dr. Robert C. Kolodny maintained that the number of HIV-infected people was twice the CDC's estimate and that the risk of heterosexual transmission was greater than reported. Even the American Medical Association recognizes it must educate its members because not all physicians have accurate information or are willing to believe it.

The CDC is an important authority on HIV and AIDS. CDC epidemiologists have studied the AIDS virus since it was first reported in the United States, and the agency has a national clearinghouse for information about HIV. Most authorities consider studies and information that appear in CDC publications definitive. To evaluate studies or information from other sources, such as newspapers, television, and what some refer to as the "supermarket medical journals," consider these questions:

- Has the study been published in a scientific journal following peer review?
- How large a study is it — and how narrow or broad the implications?
- Has the research been duplicated?
- Have the news media provided a balanced look at the information?
- Does your state health department confirm the information?

Also consider that, although much is being learned about the scope of the HIV epidemic, the progression of HIV infection, and the promise of new treatments, a growing body of evidence continues to confirm how HIV is — and is not — transmitted.

EPILOGUE
THE CHALLENGE FOR SCHOOL LEADERS

School board members, as the policymakers who determine what should happen and how in their community's schools, are vital players in the unfolding tragedy of HIV. The opportunity exists for school boards to be heroes — to turn tragedy into triumph — by providing essential community leadership for HIV prevention education in their communities and collaborating with others to educate all who are at risk.

Local school leaders need not act in isolation in accepting the challenge. Many school districts already have exemplary programs; their experiences can help direct the efforts of other educators and local school officials. Public health officials, state education agencies, national and local organizations, and NSBA and state school boards associations are prepared and eager to provide assistance.

The challenge before school boards — to reduce the risk of HIV infection and death to the next generation — is of paramount importance. It is a challenge that all school leaders and communities must and can face.

Action Plan for HIV Education

Here is a checklist of important steps to guide planning and decision making about HIV education in local schools.

Planning

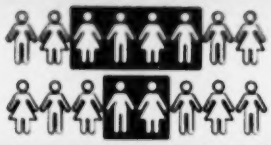
- ☐ Collect community data on the incidence of AIDS.
- ☐ Collect community data on the prevalence of teen risk behaviors and on HIV-related knowledge and attitudes.
- ☐ Find out about community HIV education efforts and resources.
- ☐ Find out about state education department and state and local health department plans, requirements, and resources.
- ☐ Identify support systems and barriers in the community.
- ☐ Establish a process for staff, parent, student, and community involvement in planning, implementation, and evaluation.
- ☐ Establish an effective communication plan.

Implementation

- ☐ Get assistance and resources from health department (local or state) and other organizations.
- ☐ Establish an advisory committee.
- ☐ Adopt policies on employees and students who have AIDS or HIV infection.
- ☐ Adopt policy on HIV education: examine and revise existing policies to assure appropriate planning, implementation, and evaluation of HIV education; develop a plan and policies to implement HIV education within a more comprehensive K-12 program of school health education.
- ☐ Support curriculum development plans with necessary resources.
- ☐ Support identified in-service plans necessary for implementation.
- ☐ Plan for evaluation of HIV education efforts.

Evaluation

- ☐ Receive periodic status reports on implementation of HIV education within the context of more comprehensive school health education.
- ☐ Receive periodic status reports on needs (HIV-related knowledge, attitudes, and behaviors among teens).
- ☐ Identify continuing or new barriers and revise plans appropriately.
- ☐ Determine success of education plan in meeting objectives.
- ☐ Revise plans as necessary.



RESOURCES

This resource list is meant to provide school officials with information to be used in developing HIV education programs. It is not an all-inclusive list, nor are the programs, organizations, or resource materials endorsed by NSBA.

Hotlines

National AIDS Hotline
U.S. Public Health Service
800/342-AIDS
800/344-SIDA (Information in Spanish)

National Gay Task Force AIDS Hotline
800/221-7044; 212/807-6016 (NY)
(Hours: Mon.-Fri. — 5:00-10:00 p.m.; Sat. — 1:00-5:00 p.m. EST)

National STD Hotline
American Social Health Association
800/227-8922 (Mon.-Fri. — 8:00 a.m.-8:00 p.m. PST); recording during nonoperating hours

Teens Teaching AIDS Prevention
The Good Samaritan Project
Kansas City, MO
1-800-234-TEEN (Mon.-Sat. — 4:00 p.m.-8:00 p.m. CST)

Organizations

AIDS Action Council
2033 M St., N.W., Suite 801
Washington, DC 20036
202/293-2886

Alan Guttmacher Institute
2010 Massachusetts Ave., N.W.
Washington, DC 20036
202/296-4012

Association for the Advancement of Health Education
1900 Association Drive
Reston, VA 22091
703/476-3437

American Association of School Administrators
1801 North Moore St.
Arlington, VA 22209
703/528-0700

American Federation of Teachers
555 New Jersey Ave., N.W.
Washington, DC 20007-3852
202/879-4548

American Foundation for AIDS Research (AmFAR)
40 West 57th St.
New York, NY 10019-4001
212/333-3118

American Medical Association
535 North Dearborn St.
Chicago, IL 60610
312/645-5334

American Red Cross
National Headquarters
1730 D St., N.W.
Washington, DC 20006
202/737-8300

American School Health Association
P.O. Box 708
Kent, Ohio 44240
216/678-1601

Center for Population Options
1012 14th St., N.W., Suite 1200
Washington, DC 20005
202/347-5700

Council of Chief State School Officers
Resource Center on Educational Equity
400 North Capitol St., N.W., Suite 379
Washington, DC 20001
202/393-8159

National AIDS Information Clearinghouse
P.O. Box 6003
Rockville, MD 20850
1-800-458-5231
(Contact this clearinghouse for copies of the Surgeon General's Report on AIDS, CDC "Guidelines for Effective School Health Education to Prevent the Spread of AIDS," and other CDC reports).

National AIDS Network
2033 M St., N.W., Suite 800
Washington, DC 20036
202/293-2437

National Association of People with AIDS
2025 I St., N.W., Suite 415
Washington, DC 20006
202/429-2856

National Association of State Boards of Education
1012 Cameron St.
Alexandria, VA 22314
703/684-4000

National Coalition of Advocates for Students
100 Boylston St., Suite 737
Boston, MA 02116
617/357-8507

National Coalition of Hispanic Health and Human Services Organizations
1030 15th St., N.W., Suite 1053
Washington, DC 20005
202/371-2100

National Council of Churches
AIDS Task Force
475 Riverside Drive, Room 572
New York, NY 10115
212/749-1214

National Education Association
The Health Information Network
100 Colony Square, Suite 200
Atlanta, GA 30361
404/875-8819

National Minority AIDS Council
714 G St., S.E.
Washington, DC 20003
202/544-1076

National Network of Runaway and Youth Services, Inc.
905 6th St., S.W., Suite 411
Washington, DC 20024
202/488-0739

National Organization of Black County Officials
440 First St., N.W., Suite 500
Washington, D.C. 20001
202/347-6963

The National PTA
700 North Rush St.
Chicago, IL 60611
312/787-0977

National Rural and Small Schools Consortium
National Rural Development Institute
Miller Hall 359, Suite 500
Western Washington University
Bellingham, WA 98225
206/676-3576

Planned Parenthood Federation of America
810 7th Ave.
New York, NY 10019
212/541-7800

San Francisco AIDS Foundation
333 Valencia St., 4th Floor
San Francisco, CA 94103-6182
415/864-4376

Sex Information and Education Council of the U.S. (SIECUS)
32 Washington Pl., 5th Floor
New York, NY 10003
212/673-3850

U.S. Conference of Mayors
1620 Eye St., N.W., 4th Floor
Washington, DC 20006
202/293-7330

U.S. Public Health Service
Public Affairs Office
Room 725-H
200 Independence Ave., N.W.
Washington, DC 20201
202/245-6867

Young Adult Institute
460 W. 34 St.
New York, NY 10001-2382
212/563-7474

Background and Information Sources

AIDS and Adolescents: The Time for Prevention Is Now and *AIDS and Adolescents: Resources for Educators*. Center for Population Options, 1012 14th St., N.W., Washington, DC; 202/347-5700.

The AIDS Catalog. AIDS International Information Distribution Service, P.O. Box 2008, Saratoga, CA 95070; 408/866-6303.

The AIDS Challenge: Prevention Education for Young People, ed. Marcia Quackenbush and Mary Nelson with Kay Clark, 1988. Network Publications, ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061-1830; 408/438-4080.

AIDS Education: Curriculum and Health Policy (Fastback 265), William L. Yarber. Phi Delta Kappa, 8th & Union, Box 789, Bloomington, IN 47402.

AIDS and the Education of Our Children: A Guide for Parents and Teachers. U.S. Department of Education, Office of Public Affairs, 400 Maryland Ave., S.W., Washington, DC 20202.

AIDS Educator: A Catalog of AIDS Educational Material. San Francisco AIDS Foundation, 333 Valencia St., 4th Floor, San Francisco, CA 94103; 415-864-4376.

AIDS Education at Home and School: An Activity Guide for Local PTA Leaders. The National PTA, 700 North Rush St., Chicago, IL 60611-2571; 312/787-0977.

AIDS and Safer Sex Education: An Annotated Bibliography of Print and Audio-Visual Materials for Sale. SIECUS, 32 Washington Pl., New York, NY 10003; 212/673-3850.

AIDS Information Resources Directory. American Foundation for AIDS Research (AmFAR), 40 West 57 St., New York, NY 10019-4001; 212/333-3118.

AIDS School Health Education Subfile, Combined Health Information Database (CHID), Centers for Disease Control. BRS Information Technologies, 1200 Route 7, Latham, NY 12110; 800/345-4277.

And the Band Played On, Randy Shilts, 1987. St. Martin's Press, 175 Fifth Ave., New York, NY 10010.

Confronting AIDS: Directions for Public Health, Health Care, and Research, 1986, and *Confronting AIDS: Update 1988*, Institute of Medicine, National Academy of Sciences. National Academy Press, 2101 Constitution Ave., N.W., Washington, DC 20418.

Criteria for Evaluating an AIDS Curriculum, rev. 1988. National Coalition of Advocates for Students (NCAS), 100 Boylston St., Boston, MA 02116; 617/357-8507.

Dealing with AIDS: Breaking the Chain of Infection, 1988. American Association of School Administrators, 1801 N. Moore St., Arlington, VA 22209; 703/528-0700.

Educating About AIDS, 1988 Supplemental Catalog. Network Publications, ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061; 408/438-4080.

Effective AIDS Education: A Policymaker's Guide, 1988. National Association of State Boards of Education, 1012 Cameron St., Alexandria, VA 22314; 703/684-4000.

Publications from Planned Parenthood (catalog). Planned Parenthood Federation of America, Inc., Education Department, 810 Seventh Ave., New York, NY 10019; 212/541-7800.

Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic, 1988. U.S. Government Printing Office, Washington, DC 20402.

Schools Face the Challenge of AIDS, 1989. Education Development Center, Inc., 55 Chapel St., Newton, MA 02160; 617/969-7100.

SIECUS Information and Service Library. Sex Information and Education Council of the U.S., 32 Washington Pl., New York, NY 10003; 212/673-3850.

Curricula

(Many state education departments have developed HIV education curricula; AIDS/HIV education coordinators for each state education agency are listed later in this section.)

AIDS: What You Should Know (5-8) and *AIDS: Understanding and Prevention* (9-12), (Student and Teacher Editions), Linda Meeks and Phil Heit, 1988. Merrill Publishing Co., 936 Eastwind Drive, Westerville, OH 43081; 614/890-1111.

AIDS: What Young Adults Should Know (Instructor's Manual and Student Guide), William Yarber, 1987. American

Alliance for Health, Physical Education, Recreation, and Dance (AAHPERD), Publications, P.O. Box 704, Waldorf, MD 20601; 703/476-3400.

Does AIDS Hurt?: Educating Young Children About AIDS (to age ten), 1988. Network Publications, ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061; 213/438-4060.

Educator's Guide to AIDS and Other STDs, Stephen R. Sroka, 1987. Health Education Consultants, 1284 Manor Park, Lakewood, OH 44107; 216/521-1766.

Explaining AIDS to Children, Inon Schenker, 1988. AIDS Educational Fund, P.O. Box 7956, Jerusalem, Israel.

Growing Healthy, 1989 (rev.). National Center for Health Education, 30 East 29 St., New York, NY 10016; 212/689-1886.

Guide to Teaching About AIDS, 1988. (Film, student pamphlet, parent pamphlet also available.) National Safety Council, 444 North Michigan Ave., Chicago, IL 60611; 312/527-4800.

The Immune System and AIDS, Inon Schenker, 1988. AIDS Educational Fund, P.O. Box 7956, Jerusalem, Israel.

Into Adolescence: Learning About AIDS (5-8), 1988. Network Publications, ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061; 213/438-4060.

Preventing AIDS, 1988. Education Development Center, Inc., 55 Chapel St., Newton, MA 02160; 617/969-7100.

STATS: Students Teaching AIDS to Students, 1988. American Medical Student Association, 1890 Preston White Drive, Reston, VA 22091; 703/620-6600.

Teaching AIDS: A Resource Guide on Acquired Immune Deficiency Syndrome, Marcia Quackenbush and Pamela Sargent, 1988 Edition. Network Publications, P.O. Box 1830, Santa Cruz, CA 95061; 213/438-4060.

Teenage Health Teaching Modules (THTM), 1989 (rev.). Education Development Center, Inc., 55 Chapel St., Newton, MA 02160; 617/969-7100.

Audiovisuals

A Letter from Brian, 1987. American Red Cross (contact your local chapter or regional operations headquarters).

AIDS: Answers for Young People, 1987. Churchill Films, 662 North Robertson Blvd., Los Angeles, CA 90069; 800/334-7830; in CA, 213/657-5110.

AIDS: Everything You Should Know, 1987. AIMS Media, 6901 Woodlely Ave., Van Nuys, CA 91406; 800/367-2467.

The AIDS Movie, 1987 (rev.). New Day Films, 22 Riverview Dr., Wayne, NJ 07470; 201/633-0212.

AIDS: What Do We Tell Our Children?, Disney Educational Productions. Coronet/MTI Film & Video, 108 Wilmot Rd., Deerfield, IL 60015; 1-800/621-2131; in IL and AL, 312/940-1260 (collect).

AIDS: What Every Student Should Know, 1986, Maryland Dept. of Education. International Telecommunication Services, Inc., P.O. Box 1290, State College, PA 16804.

AIDS: What Everyone Needs to Know (rev). Churchill Films, 662 North Robertson Blvd., Los Angeles, CA 90069; 800/334-7830; in CA, 213/657-5110.

Beyond Fear (Three parts: *The Virus; The Individual; The Community*), 1986. American Red Cross (contact your local chapter or regional operations headquarters).

Choices: Learning About AIDS, 1988. National Safety Council, 444 North Michigan Ave., Chicago, IL 60611. (Administrator's and Teaching Guides and pamphlets for students and parents also available.)

Don't Forget Sherrie, 1988. American Red Cross (contact your local chapter or regional operations headquarters).

Drugs and AIDS: Getting the Message Out, 1988 (produced by State of the Art, Inc. for the National Institute on Drug Abuse). WETA Educational Activities, P.O. Box 2626, Washington, DC 20013; 703/998-2709.

Face to Face with AIDS, 1988 (produced by Novela Health Foundation). Karol Media, 22 Riverview Drive, Wayne, NJ 07470; 201/628-9111.

I Have AIDS: A Teenager's Story, 1988 (produced by The Children's Television Workshop; contact your local Public Broadcasting Station affiliate for information on acquisition).

Sex, Drugs, and AIDS, 1986. ODN Productions, 74 Varick St., Suite 304, New York, NY 10013; 212/431-8923.

The Subject Is AIDS, 1987. ODN Productions, 74 Varick St., Suite 304, New York, NY 10013; 212/431-8923.

'Til Death Do Us Part, 1988. New Day Films, 22 Riverview Drive, Wayne, NJ 07470; 201/633-0212.

Understanding AIDS, 1987 (one of six comprising the series Challenges and Choices). GEMINI Productions, Box 541, Winchester, MA 01890; 617/729-9585.

Miscellaneous Instructional Resources

AIDS (Acquired Immune Deficiency Syndrome), (comic book), 1987. Commercial Comics, Inc., 1500 Massachusetts Ave., N.W., Washington, DC 20005.

AIDS (puppet program). The Kids on the Block Puppet Programs, 9385-C Gerwig Lane, Columbia, MD 21046; 301/290-9095; 800/368-KIDS.

The Parent-Teen AIDS Education Program: Talking with Teens, 1988 (manual, video, brochure). San Francisco AIDS Foundation, 333 Valencia St., 4th Floor, P.O. Box 6182, San Francisco, CA 94101-6182; 415/861-3397.

Teens & AIDS: Playing It Safe (brochure). American Council of Life Insurance, Health Insurance Association of America, 1001 Pennsylvania Ave., N.W., Washington, DC 20004.

School Board Policy Resources

AIDS and the Public Schools, Leadership Reports, Volume 1, 1986. National School Boards Association, 1680 Duke St., Alexandria, VA 22314; 703/838-6722.

NSBA/Educational Policies Service (EPS), Policy Information Clearinghouse, National School Boards Association, 1680 Duke St., Alexandria, VA 22314; 703/838-6722.

Policy services of state school boards associations; contact your state school boards association for information.

Communication and Community Relations

Workshops and publications are offered by many state school boards associations; contact your state school boards association for information.

Workshops and publications are offered by the National School Public Relations Association (NSPRA), 1501 Lee Highway, Arlington, VA 22209; 703/528-5840.

State Health Department and Education Department AIDS/HIV Coordinators

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434 Monroe St., Room 668
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205/261-5017

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Division of Public Health
3601 C St., Suite 540
Anchorage, AK 99524-0249
907/561-4406

Helen Mehrkens
Department of Education
Office of Instructional Improvement & Evaluation
Box F
Juneau, AK 99811-0500
907/465-2841

American Samoa

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Department of Education
Division of Curriculum & Instruction
Pago Pago, American Samoa 96799
684/633-1246

Arizona

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Division of Disease Prevention
Office of Infectious Disease
3008 North 3rd St., Room 103
Phoenix, AZ 85012
602/230-5836

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School Improvement Unit
1535 West Jefferson
Phoenix, AZ 85007
602/255-3052

Arkansas

Monte D. Meador
Arkansas Department of Health
Sexually Transmitted Diseases
4815 West Markham, Room 455
Little Rock, AR 72205
501/661-2133

Gary Parish
Department of Education
Curriculum & Assessment Section
4 Capitol Mall
Little Rock, AR 72201
501/682-4472

California

Ernie Montez
Office of AIDS
California Department of Health
1812 14th St., Room 200
Sacramento, CA 95814
916/445-0553

Beverly Bradley
Department of Education
Office of Critical Health Initiatives
721 Capitol Mall, P.O. Box 944272
Sacramento, CA 94244-2720
916/322-3209

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Department of Health
STD Control Program
4210 East 11 Ave.
Denver, CO 80220
303/331-8320

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201 East Colfax
Denver, CO 80203
303/866-6664

Connecticut

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203/566-2048

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State Department of Education
Division of Education Support Services
165 Capital Avenue
Hartford, CT 06145
203/566-3461

Delaware

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Building G
Wilmington, DE 19808
302/995-8422

Edith P. Vincent
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Townsend Building
P.O. Box 1402
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302/763-4885

District of Columbia

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1411 K St., N.W., Suite 1300
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415 12th St., N.W.
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Florida

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Health and Rehab Services
1317 Winewood Blvd.
Tallahassee, FL 32303
904/487-2478

Mae Waters
Department of Education
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1701 Capitol
Tallahassee, FL 32399
904/488-1611

Georgia

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Department of Human Resources
Community Health Section
878 Peachtree St., N.E., Room 102
Atlanta, GA 30309
404/894-6428

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Division of General Instruction
1954 Twin Towers East
Atlanta, GA 30334
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Guam

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Hawaii

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3627 Kilauea Ave., Suite 304
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808/548-4580

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Office of Instructional Services
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Honolulu, HI 96810
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Idaho

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Department of Health and Welfare
Bureau of Preventive Medicine
450 West State St.
Boise, ID 83720
208/334-5930

Shannon L. Page
Department of Education
Bureau of Instruction
650 West State St.
Boise, ID 83720
208/334-2281

Illinois

Chet Kelly
Director, AIDS Section
Department of Public Health
100 West Randolph, Suite 6-600
Chicago, IL 60602
312/917-4846

J. Robert Sampson
State Board of Education
Curriculum Improvement
100 North 1st St.
Springfield, IL 62777
217/782-2826

Indiana

Gordon Reeve
State Board of Health
1330 W. Michigan St.
Indianapolis, IN 46206-1964
317/633-8520

Phyllis Land Usher
Department of Education
Division of Student Services
State House, Room 229
Indianapolis, IN 46204-2798
317/232-6610

Iowa

Jack Kelley
Department of Health
Division of Disease Prevention
Lucas State Office Building
Des Moines, IA 50319
515/281-6438

Maryellen S. Knowles
Department of Education
Bureau of Instruction & Curriculum
Grimes State Office Building
Des Moines, IA 50319-0146
515/281-3199

Kansas

Robert French
Health and Environment
Epidemiology
Forbes Field
Topeka, KS 66620
913/867-9360, 296-5587

Tom Walsh
Department of Education
Educational Assistance Section
120 East 10th St.
Topeka, KS 66612
913/296-3851

Kentucky

Reginald Finger
Kentucky AIDS Project
Department of Health Services
275 East Main St.
Frankfurt, KY 40621
502/564-4804

Gene Fitzhugh
Department of Education
Curriculum & Staff Development
Capital Plaza Tower, 18th Floor
Frankfort, KY 40601
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Louisiana

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Health and Human Resources
VD Control Section
P.O. Box 60630
New Orleans, LA 70160
504/568-5275

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Maine

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ABOUT NSBA

The National School Boards Association is located in Alexandria, Virginia, within the Washington, D.C., metropolitan area. NSBA is a not-for-profit organization whose primary mission is the general advancement of public education through the unique North American system of representative and participatory government, whereby elementary and secondary school policy is decided by local school board members who are directly accountable to the community. Over 95% are elected, and the remainder are appointed by elected officials.

Federation Members of NSBA are the 49 state associations of local school boards, the Hawaii State Board of Education, and the boards of education in the District of Columbia and the U.S. Virgin Islands.

NSBA promotes the quality of public elementary and secondary schools through services to its Federation Members and local school boards; by increasing school board impact on federal education laws and regulations; and by maintaining liaison with other education organizations and governmental authorities.

In so doing, NSBA represents the interests of school boards before Congress, federal agencies and in court cases relating to education; provides education and training programs for school board members; provides school district management services, and offers to school boards a variety of other services including an annual convention and the Institute for the Transfer of Technology to Education (ITTE).

The NSBA Federal Relations Network, composed of up to three school board members in each Congressional district, plays a major role in NSBA's education advocacy program in Washington, D.C.

Three major publications are produced by NSBA: the award-winning monthly magazine, *The American School Board Journal*; the monthly magazine, *The Executive Educator*; and a fortnightly newspaper, *School Board News*.

Seven constituent groups within the Federation play a significant role in NSBA's efforts to serve Federation Member and school board needs:

- The Council of Urban Boards of Education focuses on the unique needs of urban school boards.
- The Large District Forum serves the special needs of large but non-urban school districts.
- The Rural District Forum serves rural and small enrollment districts.
- The Federation Member Executive Directors' NSBA Liaison Committee links the top executives within the Federation.
- The Council of School Attorneys focuses on issues of school law.
- The Conference of School Boards Association Communicators serves NSBA and Federation Member communications professionals.
- The Federal Policy Coordinators Network focuses on the administration of federally funded programs.

NSBA maintains close liaison with other groups, such as the National Caucus of Black School Board Members, National Caucus of Hispanic School Board Members, National Caucus of Young School Board Members, National Association of State Boards of Education, American Association of School Administrators, Forum of Education Organization Leaders (FEOL), Education Leaders Consortium (ELC), National Governors' Association, National Conference of State Legislatures, and Education Commission of the States.

Founded in 1940, NSBA represents the nation's 97,000 school board members who, in turn, represent the more than 40 million public school children in the U.S., which account for about 90% of all elementary and secondary school students in the nation. Over 1,800 local school boards are NSBA Direct Affiliates.

NSBA policy is determined by a 150-member Delegate Assembly composed of active school board members across the country. Translating this policy into action programs is a Board of Directors consisting of 21 members and three *ex-officio* members. The executive director administers NSBA programs, assisted by a professional staff.

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